KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2021

LARGE GROUP

GROUP AGREEMENT

City and County of Denver
Denver Fire Department
Denver Police Department

GROUP AGREEMENT

THIS AGREEMENT to purchase the attached policies is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "City" or "Group") and **KAISER FOUNDATION HEALTH PLAN OF COLORADO** (the "Health Plan") and together (the "parties").

The parties agree as follows:

INTRODUCTION

For each Group, this Group Agreement ("*Agreement"*), including any of the following that are attached: Rate Sheet(s), the Evidence of Coverage brochure(s) ("EOC"), and the Performance Guarantees (attached hereto and collectively incorporated herein as **Exhibit A**), and any amendments thereto, constitute the entire contract between the group named on the Rate Sheet ("Group") and Kaiser Foundation Health Plan of Colorado ("Health Plan"). If any of the above-named documents are not attached hereto, Health Plan must send those documents to the City as soon as possible and the Executive Director will file those documents with the Clerk's office and have them associated with this Agreement in the public record.

In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *Evidence of Coverage* document for terms you should know. Pursuant to this *Agreement,* Health Plan will provide covered Services to Members in accordance with the attached *Evidence of Coverage* documents.

WELLNESS PROGRAMS AND GROUP WELLNESS INVESTMENT FUNDS OR CREDITS

The Health Plan shall make available certain wellness programs ("**Wellness Programs**") for the Group to select from during the contract year. The Group's selection will be at the discretion of the Executive Director of the Office of Human Resources or the Executive Director's designee ("**Executive Director**").

To facilitate efficient management and operation of the programs, the Health Plan will designate wellness investment "funds" or "credits" to be used in administering the selected Wellness Programs. Any reference to cash, payments or funds to be spent, charged or credited in each of the Wellness Program detail, shall be a reference to the credits or funds described in this paragraph. The City shall not be liable for any other payment of funds to the Health Plan for the Wellness Programs selected.

At the discretion of the Executive Director, the Group can charge against the wellness investment funds or credits as directed by the City after disclosure of the program descriptions. Documents related to the Health Plan Wellness Programs to be disclosed to the City and associated with this agreement in the public record are:

1. Workforce Health Package Letter,
2. Workforce Health Programs Document,

3. “Weigh and Win” program.

If any of the above-named Health Plan Wellness Program documents are not attached hereto, the Health Plan must send those documents to the City as soon as possible and the Executive Director will file those documents with the Clerk’s office and have them associated with this Agreement in the public record.

WELLNESS PLATFORM SOFTWARE PAYMENT

The parties agree that the City needs to implement a wellness platform software to support the City employee wellness effort and successfully administer the City's wellness program through the use of centralized wellness data. For that reason, Health Plan agrees to pay $250,000 to the workplace wellness software provider identified by the Executive Director for the purchase and implementation of a wellness platform software that the City will maintain. Such payment will be paid in full no more than 30 days after invoicing. Health Plan agrees that the wellness platform software payment will not reduce the "funds" or "credits" used toward Wellness Programs, as defined herein, and further, the wellness platform software payment will not be funded through increased Group premiums.

COORDINATION OF POLICY PURCHASE AND LIMITED SIGNATURE AUTHORIZATION

Health Plan shall fully coordinate the purchase of agreed policies with the Executive Director. The Executive Director shall be authorized to sign any documents reasonably related to, and any other policy or wellness-related documents necessary for implementation or administration of the City’s policies as intended herein. The Executive Director’s signature cannot expand the City’s liability in any way, or limit the benefits contemplated herein.

TERM OF *AGREEMENT* and RENEWAL

Term of *Agreement*

This *Agreement* is effective for the term beginning **January 1, 2021**, and shall terminate at 11:59 p.m. on **December 31, 2021**, unless terminated as set forth in the "Termination of *Agreement*" section.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew this *Agreement*.

Group must provide Health Plan with at least 60 days’ prior written notice if Group does not want to enter into a new agreement with Health Plan, as described under “Termination on Notice” in the “Termination of Agreement” section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on an Anniversary Date

Upon 60 days prior written notice to Group with respect to proposed benefit or contract changes, or upon 30 days prior written notice to Group with respect to proposed rate changes, or as otherwise agreed to by Health Plan and Group, Health Plan may offer to extend the term of this *Agreement* and propose amendments to this *Agreement* to be effective on any year’s Anniversary Date (the Anniversary Date is shown on the Rate Sheet). Except as otherwise expressly stated in this

Agreement, all amendments, including but not limited to benefit, contract and rate changes, must be mutually agreed upon in advance and in writing by Health Plan and Group.

Amendments Related to Government Approval or Mandated by Law

If Health Plan notified Group that Health Plan had not received all necessary government approvals related to this *Agreement*, Health Plan may propose to amend this *Agreement* by giving written notice to Group after receiving all necessary government approvals. Any such government-approved provisions go into effect on the Anniversary Date that next follows the Health Plan's original notice to Group of the provisions for which it had sought government approval (unless the government requires a later effective date), if the *Agreement* is renewed.

Amendment Due to Medicare Changes

Health Plan contracts on a calendar-year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this Agreement to change any Senior Advantage EOCs and Premiums effective **January 1, 2021** (unless the federal government requires a different effective date). The amendment may include an increase or decrease in Premiums and Benefits including Member Cost Sharing and any Medicare Part D coverage level thresholds; however, premium increases and Member Cost Sharing increases may not be made retroactive to a prior month. Health Plan will give Group at least 30 days advance written notice of any such amendment, so long as Health Plan is given 30-days' notice of such changes by CMS or other governmental entity.

Service Area

Health Plan may amend this *Agreement* at any time by giving written notice to Group, via certified mail, in order to expand the Health Plan Service Area.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end at 11:59 p.m. on the termination date, except as expressly provided in the *Evidence of Coverage*, if attached, and except as otherwise required by applicable law.

Health Plan will give Group written notice to the Executive Director and City Attorney's office at the addresses shown in the Notices section, via certified mail, if this *Agreement* terminates. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 30 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the

termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 60 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

Termination for Nonpayment

Health Plan may terminate this *Agreement* by giving advance written notice to Group, via certified mail, if Group fails to make any past-due Premiums payment during Health Plan's grace period. The advance written notice will indicate the termination date. A grace period of 31 days is observed by Health Plan, during which time the amounts specified in the Rate Sheet may be paid by the Group without loss of benefits. The grace period shall apply to all payments except the first payment and coverage shall remain in effect if payment is made during the grace period. Group is liable for all unpaid Premiums through the termination date. In the event that any Premiums payment is not timely received by Health Plan, Health Plan will send the Group a notice of Premiums owed. Such notice shall specify the delinquent Premiums payment and the date upon which the 31 day grace period ends. Health Plan will give written notice to Group of final termination of this *Agreement* via certified mail.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members in order to comply with CMS termination notice requirements.

Termination for Fraud or for Intentionally Furnishing Materially Misleading or Fraudulent Information

If Group commits fraud or intentionally furnishes materially misleading or fraudulent information to Health Plan, Health Plan may terminate this *Agreement* by giving advance notice to the Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's contribution or participation requirements as set forth in

the “Contribution and Participation Requirements” section of this *Agreement*, Health Plan may terminate this *Agreement* by giving sixty (60) days advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Movement outside the Service Area
Health Plan may terminate this *Agreement* upon 30 days prior written notice, via certified mail, to Group if no eligible person lives, resides, or works in Health Plan’s Service Area as described in the *Evidence of Coverage.*

Termination for Discontinuance of a Product or all Products within a Market
Health Plan may terminate a particular product or all products offered in the group market as permitted by law. If Health Plan discontinues offering a particular product in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice, via certified mail, to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days written notice, via certified mail, to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct evidence of coverage.

PREMIUMS

Only Members for whom Health Plan has received the appropriate Premiums payment listed on the Rate Sheet are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan has received appropriate payment.

If Group does not prepay the Full Premiums by the first of the coverage month or by the date otherwise agreed to by Health Plan and Group, the Premiums may include an additional administrative charge upon renewal. “Full Premiums” means 100 percent of monthly Premiums for each enrolled Member, as set forth in this “Premiums” section.

Premiums Rebates
If state or federal law requires Health Plan to rebate Premiums from this or any earlier contract year and Health Plan rebates Premiums to Group, Group represents that Group will use that rebate in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

New Members
Premiums are payable for the entire month for new Members unless otherwise agreed to by Health Plan.

Terminating Members
Pursuant to C.R.S. 10-16-103.5, Premiums are payable for each Member:

- Through the date that Health Plan receives written notice from Group that a Member is no longer eligible or covered;

- Through the date that Health Plan receives written notice from Group that it no longer intends to maintain coverage for its Members through Health Plan; or

- Through the date that the Member covered under the policy is no longer eligible or covered if the policyholder notifies the Health Plan within ten (10) business days after the date that the Member is no longer eligible or covered because the Member left employment without notice to the Group or the Member is an employee whose employment was terminated for gross misconduct.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations
Group must give Health Plan 30 days prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or want Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan receives a termination notice on March 5, for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination
If Health Plan receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage
This "Subscriber Contributions for Medicare Part C Coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute

toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
    - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category
    - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C Premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium.

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section, applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D coverage. Group's Senior Advantage Premiums include the Medicare Part D premium. Group may determine how much it will require Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family Unit, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
    - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job. Group will not require different Subscriber contributions toward the Medicare Part D category, and are not based on eligibility for the Part D "Low Income Subsidy" (a subsidy described in 42 C.F.R. 423 Subpart P, which is offered by the Medicare Program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduces the Medicare beneficiaries' Medicare Part D premiums or Medicare Part D cost-sharing amounts).
    - Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class.
- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member who exceeds the Premiums for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premiums.
- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage premium for the same

month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance.

- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount.

Late Enrollment Penalty
If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of that penalty.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS
No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan is timely notified in writing. If Group fails to satisfy the Contribution and Participation Requirements of this section, the Health Plan may terminate this *Agreement* as set forth in the **Termination for Violation of Contribution or Participation Requirements** in this *Agreement*. The Group must:

- Contribute to all health care plans available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan.

- Ensure that:
  - All eligible employees enrolled in Health Plan meet the eligibility requirements of the Group.
  - All eligible employees enrolled in Health Plan are covered by Workers' Compensation, unless not required by law to be covered.
  - All Health Plan Subscribers live or work inside Health Plan's Service Area when they enroll.
  - The number of active, eligible employee Subscribers enrolled under this *Agreement* does not fall below 10.

- There is a bona fide employer/employee relationship to those offered our plan, except eligible Taft-Hartley trusts and partnerships, and except as otherwise set forth in the agreed upon eligibility requirements.

- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group.

- Meet all applicable legal and contractual requirements, such as:

  Group must adhere to all requirements set forth in the applicable *Evidence of Coverage*, as amended.

  - Group must obtain Health Plan's prior written approval of any Group eligibility or participation or contribution requirements that are not stated in the applicable *Evidence of Coverage*, as amended.

  - Group must use Member enrollment application forms that are provided or approved by Health Plan.

  - Comply with Centers for Medicare & Medicaid Services (CMS requirements governing enrollment in, and disenrollment from Kaiser Permanente Senior Advantage (KPSA)).

- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group.

- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*, except as restricted by the laws of the City, State of Colorado law, or federal law.

Self-Verification of Member Eligibility

Group agrees to assume responsibility for self-verifying the eligibility of its enrolled Members. Such self-verification includes obtaining and verifying the accuracy of any and all supporting documentation received from Groups employees and eligible Dependents. In addition, Group will provide eligibility data to Health Plan that includes coverage effective dates for Group's employees and eligible Dependents to prove that eligibility complies with all applicable federal and state laws and regulations. Upon request, Group will make all verification data and documentation available to Health Plan. Health Plan reserves the right to inspect the verification data and documentation for any reason, at any time during the term of the *Agreement* and up to five (5) years thereafter.

Group further agrees to provide Health Plan with timely notification of enrollment and cancellation of enrolled Dependents, as specified in the "Eligibility and Enrollment" and "Termination of Membership" sections of the *Evidence of Coverage*.

LIABILITY INSURANCE

Health Plan shall, at its own cost and expense, maintain in full force and effect, during the term of this *Agreement*, professional (malpractice) and general liability insurance with minimum limits of at least $10,000,000 per occurrence. All such policies shall provide for the Group to receive at least thirty (30) days written notice from the insurance carrier or carriers prior to any cancellation or material change in any such policy. Health Plan shall provide to the Group, upon execution of this

Agreement, and upon renewal of such insurance programs certificates of insurance for all such insurance carried. All insurance coverage must be written by companies authorized to do business in the State of Colorado. All such insurance shall cover claims occurring during the term of this *Agreement*, including claims which may be asserted after the termination of this *Agreement*. Notwithstanding the foregoing, Health Plan may utilize a combination of insurance and alternative risk management programs, including self-insurance to provide for its contractual obligations under this *Agreement*. Evidence of such financial responsibility will be provided upon execution of this *Agreement.* Health Plan shall maintain Business Automobile Liability with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement. Each of the Health Plan's agreements with providers in its provider network does, and during the initial term and any renewal term of this *Agreement*, will require maintenance of levels of professional liability insurance consistent with industry standards and applicable law.

Health Plan covenants and agrees that at all times it will maintain and carry statutory workers' compensation insurance with an authorized insurance company or through an authorized self-insurance plan approved by the State of Colorado. Such insurance shall insure payment for such workers' compensation claims to all of Health Plan's employees, including specifically but not by way of limitation, all of its employees who in any manner perform work or provide services to fulfill Health Plan's obligations under this *Agreement*. Health Plan agrees to provide the Administrator with certificates, in number as required, satisfactorily evidencing the existence of the Workers' Compensation insurance. There shall be a waiver of subrogation in favor of the City for Workers' Compensation and professional errors and omission coverage**.**

Insurance coverage specified herein constitutes the minimum requirements, and said requirements shall in no way lessen or limit the liability of Health Plan under the terms of the *Agreement*. Health Plan shall procure and maintain, at its own expense and cost, any additional kinds and amounts of insurance that, in its judgment, may be necessary for its proper protection in the prosecution of the services hereunder.

a. <u>General Conditions</u>: Health Plan agrees to secure, at or before the time of execution of this Agreement, the following insurance covering all operations, goods or services provided pursuant to this Agreement. Health Plan shall keep the required insurance coverage in force at all times during the term of the Agreement, or any extension thereof, during any warranty period, and for three (3) years after termination of the Agreement. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-" VIII or better. Each policy shall contain a valid provision or endorsement requiring notification to the City in the event any of the above-described policies be canceled or non-renewed before the expiration date thereof. Such written notice shall be sent to the Parties identified in the Notices section of this Agreement. Such notice shall reference the City contract number listed on the signature page of this Agreement. Said notice shall be sent thirty (30) days prior to such cancellation or non-renewal unless due to non-payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer,

Health Plan shall provide written notice of cancellation, non-renewal and any reduction in coverage to the Parties identified in the Notices section by certified mail, return receipt requested within three (3) business days of such notice by its insurer(s) and referencing the City's contract number. If any policy is in excess of a deductible or self-insured retention, the City must be notified by the Health Plan. Health Plan shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Health Plan. The Health Plan shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

b. Proof of Insurance: Health Plan shall provide a copy of this Agreement to its insurance agent or broker. Health Plan may not commence services or work relating to the Agreement prior to placement of coverages required under this Agreement. Health Plan agrees to provide a certificate of insurance to the City, preferably an ACORD certificate, that complies with all insurance requirements of this Agreement. Health Plan will self-insure for any insurance requirements not maintained. The City requests that the City's contract number be referenced on the Certificate. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Health Plan's breach of this Agreement or of any of the City's rights or remedies under this Agreement. The City's Risk Management Office may require additional proof of insurance, including but not limited to policies and endorsements.

c. Additional Insureds: For Commercial General Liability, Auto Liability, Professional Liability, Cyber (PII, Data) and Excess Liability/Umbrella (if required) Health Plan and subcontractor's insurer(s) shall include the City and County of Denver, its elected and appointed officials, employees and volunteers as additional insured.

d. Waiver of Subrogation: For all coverages required under this Agreement, Health Plan's insurer shall waive subrogation rights against the City.

e. Subcontractors and Subconsultants: All subcontractors and subconsultants (including independent contractors, suppliers or other entities providing goods or services required by this Agreement) shall be subject to all of the requirements herein and shall procure and maintain the same coverages required of the Health Plan. Health Plan shall include all such subcontractors as additional insured under its policies (with the exception of Workers' Compensation) or shall ensure that all such subcontractors and subconsultants maintain the required coverages. Health Plan agrees to provide proof of insurance for all such subcontractors and subconsultants upon request by the City.

f. **Workers' Compensation/Employer's Liability Insurance:** Health Plan shall maintain the coverage as required by statute for each work location and shall maintain Employer's Liability insurance with limits of $100,000 per occurrence for each bodily injury claim, $100,000 per occurrence for each bodily injury caused by disease claim, and $500,000 aggregate for all bodily injuries caused by disease claims. Health Plan expressly represents to the City, as a material representation upon which the City is relying in entering into this Agreement, that none of the Contractor's officers or employees who may be eligible under any statute or law to reject Workers' Compensation Insurance shall effect such rejection during any part of the term of this Agreement, and that any such rejections previously effected, have been revoked as of the date Contractor executes this Agreement.

g. **Commercial General Liability**: Health Plan shall maintain a Commercial General Liability insurance policy with limits of $1,000,000 for each occurrence, $1,000,000 for each personal and advertising injury claim, $2,000,000 products and completed operations aggregate, and $2,000,000 policy aggregate.

h. **Business Automobile Insurance:** Contractor shall maintain Business Automobile Liability with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement.

i. **Professional Liability (Errors & Omissions):** Health Plan shall maintain limits of $1,000,000 per claim and $1,000,000 policy aggregate limit. Policy shall include a severability of interest or separation of insured provision (no insured vs. insured exclusion) and a provision that coverage is primary and non-contributory with any other coverage or self-insurance maintained by the City.

j. **Cyber Liability:** Contractor shall maintain Cyber Liability coverage with limits of $1,000,000 per occurrence and $1,000,000 policy aggregate covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security.

k. **Additional Provisions**:

(1) For Commercial General Liability, the policy must provide the following:

(a) That this Agreement is an Insured Contract under the policy;

(b) Defense costs are outside the limits of liability;

(c) A severability of interests, separation of insureds provision (no insured vs. insured exclusion); and

(d) A provision that coverage is primary and non-contributory with other coverage or self-insurance maintained by the City.

(2) For claims-made coverage:

(a) The retroactive date must be on or before the contract date or the first date when any goods or services were provided to the City, whichever is earlier.

(b) Health Plan shall advise the City in the event any general aggregate or other aggregate limits are reduced below the required per occurrence limits. At their own expense, and where such general aggregate or other aggregate limits have been reduced below the required per occurrence limit, the Health Plan will procure such per occurrence limits and furnish a new certificate of insurance showing such coverage is in force.

PERSONAL INFORMATION AND DATA PROTECTION

a. "**Data Protection Laws**" means (i) all applicable international, federal, state, provincial and local laws, rules, regulations, directives and governmental requirements relating in any way to the privacy, confidentiality or security of Personal Information (as defined below in Paragraph b.); and (ii) all applicable laws and regulations relating to electronic and non-electronic marketing and advertising; laws regulating unsolicited email communications; security breach notification laws; laws imposing minimum security requirements; laws requiring the secure disposal of records containing certain Personal Information; laws imposing licensing requirements; laws and other legislative acts that establish procedures for the evaluation of compliance; and all other similar applicable requirements. Further, and not by way of limitation, Health Plan shall provide for the security of all City Data, and Personal Information if applicable, in accordance with all policies promulgated by Denver Technology Services, as amended, and all applicable laws, rules, policies, publications, and guidelines including, without limitation: (i) the most recently promulgated IRS Publication 1075 for all Tax Information, (ii) the most recently updated PCI Data Security Standard from the PCI Security Standards Council for all PCI, (iii) the most recently issued version of the U.S. Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Security Policy for all CJI, (iv) the Colorado Consumer Protection Act, (v) the Children's Online Privacy Protection Act (COPPA), (vi) the Family Education Rights and Privacy Act (FERPA), and (vii) Colorado House Bill 18-1128.

b. "**Personal Information**" means all information that individually or in combination, does or can identify a specific individual or from which a specific individual can be identified, contacted, or located. Personal Information includes, without limitation, name, signature, address, e-mail address, telephone number, social security number (full or partial), business contact information, date of birth, national or state identification numbers, bank account number, credit or debit card numbers, and any other unique identifier or one or more factors specific to the individual's physical, physiological, mental, economic, cultural, or social identity.

c. **Compliance with Law and Regulation**: Health Plan confirms and warrants that it complies with any and all applicable Data Protection Laws relating to the collection, use, disclosure, and other processing of Personal Information and that it will perform its obligations under this Agreement in compliance with them. This section will survive the termination of this Agreement.

d. **Software Programs; Security of Personal Information and access to Software Programs**: Health Plan will use the software programs designated by the City to collect, use, process, store, or generate all data and information, with or without Personal Information, received as a result of the Health Plan's services under this Agreement. Health Plan will fully comply with any and all requirements and conditions associated with the use of said software programs as provided by the City. In addition, Health Plan will establish and maintain data privacy and information security policies and procedures, including physical, technical, administrative, and organizational safeguards, in order to: (i) ensure the security and confidentiality of Personal Information; (ii) protect against any anticipated threats or hazards to the security or integrity of Personal Information; (iii) protect against unauthorized disclosure, access to, or use of Personal Information; (iv) ensure the proper use of Personal Information; and (v) ensure that all employees, officers, agents, and subcontractors of Health Plan, if any, comply with all of the foregoing. Health Plan shall also provide for the security of all Personal Information in accordance with all policies promulgated by Denver Technology Services, as amended, and all applicable laws, rules, policies, publications, and guidelines including, without limitation: (i) the Children's Online Privacy Protection Act (COPPA), and (ii) Colorado House Bill 18-1128. The Health Plan shall submit to the Executive Director, within fifteen (15) days of the Executive Director's written request, copies of the Health Plan's policies and procedures to maintain the confidentiality of Personal Information to which the Health Plan has access.

e. **Confidentiality; No Ownership by Health Plan**: Unless otherwise permitted expressly by applicable law, all Personal Information collected, used, processed, stored, or generated as the result of the services to be provided under this Agreement will be treated by Health Plan as highly confidential information. Health Plan will have no right, title, or interest in any Personal Information or any other data obtained or supplied by Health Plan in connection with the services to be provided under this Agreement. The City shall own all information, and other work product, with or without Personal Information, developed or obtained by Health Plan pursuant to this Agreement ("City Work Product"). Health Plan has an obligation to immediately alert the City if Health Plan's security has been breached or if Health Plan is aware of any unauthorized disclosure of Personal Information. This Section will survive the termination of this Agreement.

f. **Health Plan Use of Personal Information and City Work Product**: Health Plan will take all necessary precautions to safeguard the storage of Personal Information and City Work Product including without limitation: (i) keep and maintain Personal Information and City Work Product in strict confidence and in compliance with all applicable Data Protection Laws, and such other applicable laws, using such degree of care as is appropriate and consistent with its obligations as described in this Agreement and applicable law to avoid unauthorized access, use, disclosure, or loss; (ii) use and disclose Personal Information or City Work Product solely and exclusively for the purpose of providing the services hereunder,

such use and disclosure being in accordance with this Agreement, and applicable law; (iii) not use, sell, rent, transfer, distribute, or otherwise disclose or make available Personal Information or City Work Product for Health Plan's own purposes or for the benefit of anyone other than the City without the prior written consent of the City and the person to whom the Personal Information pertains; and (iv) not engage in "data mining" of Personal Information or City Work Product except as specifically and expressly required by law or authorized in writing by the City. This Section will survive the termination of this Agreement.

g. **Employees and Subcontractors**: Health Plan will ensure that, prior to being granted access to Personal Information or City Work Product, Health Plan Staff who perform work under this Agreement have all undergone and passed criminal background screenings; have successfully completed annual instruction of a nature sufficient to enable them to effectively comply with all data protection provisions of this Agreement; and possess all qualifications appropriate to the nature of the employees' duties and the sensitivity of the data they will be handling. Only those Health Plan Staff who have a direct need for Personal Information, City Work Product, or Confidential Information shall have access to any information provided to Health Plan under this Agreement. Prior to allowing any Health Plan Staff to access or use any Personal Information, City Work Product, or Confidential Information, the Health Plan shall require any such Health Plan Staff to review and agree to the usage and access terms outlined in this Agreement. Health Plan will inform its Health Plan Staff of the obligations under this Agreement, and all requirements and obligations of Health Plan under this Agreement shall survive the expiration or earlier termination of this Agreement. Health Plan shall not disclose Personal Information, City Work Product, or Confidential Information to subcontractors unless such subcontractors are bound by non-disclosure and confidentiality provisions at least as strict as those contained in this Agreement. Unless Health Plan provides its own security protection for the information it discloses to a third-party service provider, the Health Plan shall require the third party service provider to implement and maintain reasonable security procedures and practices that are appropriate to the nature of the Personal Information, City Work Product, or Confidential Information disclosed and reasonably designed to protect Personal Information, City Work Product, or Confidential Information from unauthorized access, use, modification, disclosure, or destruction. This Section will survive the termination of this Agreement.

h. **Loss of Personal Information or City Work Product**: In the event of any act, error or omission, negligence, misconduct, or breach that compromises or is suspected to compromise the security, confidentiality, or integrity of Personal Information or City Work Product, Health Plan will, as applicable: (i) notify the affected individual and the City as soon as practicable but no later than twenty-four (24) hours of becoming aware of such occurrence; (ii) cooperate with the affected individual and the City in investigating the occurrence, including making available all relevant records, logs, files, data reporting, and other materials required to comply with applicable law or as otherwise required by the affected individual or the City; (iii) in the case of Personal Information and if required by applicable law, at the affected individual's sole election: (A) notify the affected individuals in accordance with any legally required notification period; or, (B) reimburse the affected individual for any costs in notifying the affected individuals; (iv) in the case of Personal Information and if required by applicable law, provide third-party credit and identity monitoring services to each of the affected individuals for the period required to comply

with applicable law; (v) perform or take any other actions required to comply with applicable law as a result of the occurrence; (vi) indemnify, defend, and hold harmless the City and the affected individual for any and all claims, including reasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from the City or the affected individual in connection with the occurrence; (vii) be responsible for recovering lost data and information in the manner and on the schedule set forth by the City without charge to the affected individual, and (viii) provide to the City and the affected individual a detailed plan within ten (10) calendar days of the occurrence describing the measures Contractor will undertake to prevent a future occurrence. Notification to affected individuals, as described above, will comply with applicable law, be written in plain terms in English and in any other language or languages specified by the affected individual, and contain, at a minimum: (i) name and contact information of Contractor's representative; (ii) a description of the nature of the loss; (iii) a list of the types of data involved; (iv) the known or approximate date of the loss; (v) how such loss may affect the affected individual; (vi) what steps Contractor has taken to protect the affected individual; what steps the affected individual can take to protect himself or herself; (vii) contact information for major credit card reporting agencies; and (viii) information regarding the credit and identity monitoring services to be provided by Contractor. This Section will survive the termination of this Agreement.

i. **Data Retention and Destruction**: Using appropriate and reliable storage media, Health Plan will regularly backup all City Work Product and Personal Information used in connection with this Agreement and retain such backup copies consistent with the Health Plan's data retention policies. Upon termination of the Agreement, at the City's election, Health Plan will either securely destroy or transmit to City the City Work Product in an industry standard format. Upon the City's request, Health Plan will supply City a certificate indicating the records disposed of, the date disposed of, and the method of disposition used. With respect to City Work Product controlled exclusively by Contractor, Health Plan will immediately preserve the state of the Personal Information or City Work Product at the time of the request and place a "hold" on Personal Information or City Work Product destruction or disposal under its usual records retention policies of records that include Personal Information or City Work Product, in response to an oral or written request from City indicating that those records may be relevant to litigation that City reasonably anticipates. Oral requests by City for a hold on record destruction will be reduced to writing and supplied to Health Plan for its records as soon as reasonably practicable under the circumstances. City will promptly coordinate with Contractor regarding the preservation and disposition of these records. Health Plan shall continue to preserve the records until further notice by City. This Section will survive the termination of this Agreement.

j. **No Other Databases**: Health Plan will not establish or maintain a separate database containing Personal Information or City Work Product to provide the services under the Agreement. This Section will survive the termination of this Agreement.

k. **Data Transfer Upon Termination**: Upon termination or expiration of this Agreement and City's request, Health Plan will ensure that all Personal Information and City Work Product is securely transferred to City, or a party designated by City, within thirty (30) calendar days. Health Plan will ensure

that the data will be provided in an industry standard format. Health Plan will provide City with no less than ninety (90) calendar days' notice of impending cessation of its business or that of any Health Plan subcontractor and any contingency plans in the event of notice of such cessation. In connection with any cessation of Health Plan's business with its customers, Health Plan shall implement its contingency and/or exit plans and take all reasonable actions to provide for an effective and efficient transition of service with minimal disruption to City. Health Plan will work closely with its successor to ensure a successful transition to the new service or equipment, with minimal downtime and effect on City, all such work to be coordinated and performed in advance of the formal, final transition date mutually agreed upon by Health Plan and City. This Section will survive the termination of this Agreement.

DEFENSE AND INDEMNIFICATION

a. Health Plan hereby agrees to defend, indemnify, reimburse and hold harmless City, its appointed and elected officials, agents and employees for, from and against all liabilities, claims, judgments, suits or demands for damages to persons or property arising out of, resulting from, or relating to the work performed under this Agreement ("Claims"), unless such Claims have been specifically determined by the trier of fact to be the sole negligence or willful misconduct of the City. This indemnity shall be interpreted in the broadest possible manner to indemnify City for any acts or omissions of Health Plan or its subcontractors either passive or active, irrespective of fault, including City's concurrent negligence whether active or passive, except for the sole negligence or willful misconduct of City.

b. Health Plan's duty to defend and indemnify City shall arise at the time written notice of the Claim is first provided to City regardless of whether Claimant has filed suit on the Claim. Health Plan's duty to defend and indemnify City shall arise even if City is the only party sued by claimant and/or claimant alleges that City's negligence or willful misconduct was the sole cause of claimant's damages.

c. Health Plan will defend any and all Claims which may be brought or threatened against City and will pay on behalf of City any expenses incurred by reason of such Claims including, but not limited to, court costs and attorney fees incurred in defending and investigating such Claims or seeking to enforce this indemnity obligation. Such payments on behalf of City shall be in addition to any other legal remedies available to City and shall not be considered City's exclusive remedy.

d. Insurance coverage requirements specified in this Agreement shall in no way lessen or limit the liability of the Health Plan under the terms of this indemnification obligation. The Health Plan shall obtain, at its own expense, any additional insurance that it deems necessary for the City's protection.

e. This defense and indemnification obligation shall survive the expiration or termination of this Agreement.

MISCELLANEOUS PROVISIONS

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing one original Rate Sheet, with all signatures required by the Group, and returning it to Health Plan.

Group and Heath Plan may not change this *Agreement* unilaterally by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager, and Health Plan must contact the Group as set forth in the Amendments section of this *Agreement*. Health Plan will issue a new agreement or

amendment if Health Plan and Group agree on any changes.

Assignment
Health Plan may not assign, transfer, pledge, or hypothecate in any way this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. Notwithstanding the foregoing, if Health Plan assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this *Agreement* will continue in full force and effect as if such corporation, firm or person were a party to this *Agreement*, provided that such corporation, firm or person continues to provide prepaid health services. No duties imposed by this *Agreement* may be delegated without the approval of the other party, except that Health Plan may delegate certain functions, including but not limited to medical management, utilization review, credentialing and/or claims payment, to provider groups or other certified organizations which contract with Health Plan and that Health Plan may contract with its corporate affiliates to perform certain management and administrative services for Health Plan.

Inurement
The rights and obligations of the parties to the Agreement inure to the benefit of and shall be binding upon the parties and their respective successors and assigns, provided assignments are consented to in accordance with the terms of the Agreement.

No Third-Party Beneficiary
Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the Group or the Health Plan receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

Certificates of Creditable Coverage
This "HIPAA Certificates of Creditable Coverage" section does not apply if Group has a written agreement with Health Plan that Group will mail certificates of creditable coverage. If Group has a waiting period or affiliation period, when Group reports an enrollment of a new hire and any eligible Dependents who enroll at the same time (other than a Kaiser Permanente Senior Advantage

enrollment) with a membership effective date that occurs during the term of this *Agreement*, Group must provide the following information in a format Health Plan approves:

- Enrollment reason. (If Group does not provide an enrollment reason, Health Plan will assume that Subscriber is not a new hire, and certificate for the Subscriber and any Dependents who enrolled at the same time will indicate that there was no waiting period or affiliation period).
- Hire date of the Subscriber. (If the enrollment reason is "new hire" and Group does not provide a hire date, Health Plan will assume that the hire date is the effective date of coverage for the Subscriber and any Dependents who enrolled at the same time, and certificate for those Members will indicate there was no waiting period or affiliation period).

- Effective date of coverage.

Group has a waiting period or affiliation period if the membership effective date for a new hire and any eligible Dependents who enroll at the same time is not the hire date (for example, if the membership effective date is the first of the month following the hire date). Upon Health Plan request (whether or not Group has a waiting period or affiliation period), Group must provide any other information that Health Plan needs in order to complete certificates of creditable coverage.

When Health Plan mails a certificate of creditable coverage, the number of months of creditable coverage that Health Plan reports will be based on the information Health Plan has at the time the certificate is mailed.

Delegation of Claims Review Authority
Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits, subject to the claims review process available to the Member or other actions permitted by law and this *Agreement*. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Health Plan is a "named claims fiduciary" with respect to review of claims under this *Agreement.*

Governing Law
Except as preempted by federal law, this *Agreement* will be governed in accord with the laws of the State of Colorado and with the Charter and Revised Municipal Code of the City and County of Denver, and the ordinances, regulations, and Executive Orders enacted and/or promulgated pursuant thereto. The Charter and Revised Municipal Code of the City and County of Denver, as the same may be amended from time to time, are hereby expressly incorporated into this *Agreement* as if fully set out herein by this reference. Venue for any action brought as a result of this *Agreement* shall be in the District Court in and for the City and County of Denver. Any provision required to be in this *Agreement* by State of Colorado law or federal law shall bind Group and Health Plan whether or not set forth herein, and Health Plan will promptly notify Group if Health Plan discovers or has notice of any such provision.

Disputes
All disputes between the City and Health Plan arising out of or regarding this Agreement will be resolved by administrative hearing pursuant to the procedure established by D.R.M.C. § 56-106(b)-(f). For the purposes of that administrative procedure, the City official rendering a final determination shall be the Executive Director as defined in this Agreement. This term shall not apply to claims disputes.

Member Information
Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about proposed changes to this *Agreement*, or changes mandated by Governing Law above, or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information. Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Health Plan will provide SBCs to Members who make a request to Health Plan.

Relationship of Parties

Group is not the agent or representative of Health Plan, and shall not be liable for any acts or omissions of Health Plan, its agents or its employees, or Plan Providers. Member is not the agent or representative of Health Plan, and shall not be liable for any acts or omissions of Health Plan, its agents or its employees. Plan Providers are independent contractors and are not the agents, employees or servants of Health Plan. It is understood and agreed by and between the parties that the status of Health Plan shall be that of an independent contractor and of a corporation retained on a contractual basis to perform professional or technical services for limited periods of time as described in Section 9.1.1 (E)(x) of the Charter of the City and it is not intended, nor shall it be construed, that Health Plan's personnel are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code or for any purpose whatsoever. Health Plan shall pay when due all required employment taxes and income tax withholding, shall provide and keep in force Workers' Compensation and unemployment compensation insurance in the amounts required by law.

Taxes, Charges, and Penalties

The City is not liable for the payment of taxes, late charges or penalties of any nature, except for any additional amounts that the City may be required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, et seq. Health Plan shall promptly pay when due, all taxes, bills, debts and obligations it incurs performing the services under the Agreement and shall not allow any lien, mortgage, judgment or execution to be filed against City property.

Access to Books and Records

Health Plan and the Group shall have the right to access and examine the others' books and records for audit of compliance with the terms and conditions of this *Agreement*. Any such access shall not include the right to access any of Health Plan's books and records that would include protected health information about any of the Members in the Health Plan. However, Health Plan can provide the Group with those books and records to the extent personally identifiable information has been eliminated.

Health Plan agrees that it will keep and preserve for at least six (6) years after the final payment under this *Agreement* all directly pertinent books, documents, papers and records of Health Plan involving transactions related to this *Agreement.*

Examination of Records

In accordance with the terms of the previous section, any authorized agent of the City, including the City Auditor or his or her representative, has the right to access, and the right to examine, copy and

retain copies, at City's election in paper or electronic form, any pertinent books, documents, papers and records related to Health Plan's performance pursuant to this Agreement, provision of any goods or services to the City, and any other transactions related to this Agreement. Health Plan shall cooperate with City representatives and City representatives shall be granted access to the forgoing documents and information during reasonable business hours and until the latter of six (6) years after the final payment under the Agreement or expiration of the applicable statute of limitations. When conducting an audit of this Agreement, the City Auditor shall be subject to government auditing standards issued by the United States Government Accountability Office by the Comptroller General of the United States, including with respect to disclosure of information acquired during the course of an audit. No examination of records and audits pursuant to this paragraph shall require Health Plan to make disclosures in violation of state or federal privacy laws. Health Plan shall at all times comply with D.R.M.C. 20-276 entitled "Internal Audit".

Any authorized agent of the City, including the City Auditor or his or her representative, has the right to access and the right to examine, copy and retain copies, at City's election in paper or electronic form, any pertinent books, documents, papers and records related to Health Plan's performance pursuant to this Agreement, provision of any goods or services to the City, and any other transactions related to this Agreement. Health Plan shall cooperate with City representatives and City representatives shall be granted access to the foregoing documents and information during reasonable business hours and until the latter of three (3) years after the final payment under the Agreement or expiration of the applicable statute of limitations. When conducting an audit of this Agreement, the City Auditor shall be subject to government auditing standards issued by the United States Government Accountability Office by the Comptroller General of the United States, including with respect to disclosure of information acquired during the course of an audit. No examination of records and audit pursuant to this paragraph shall require Parties to make disclosures in violation of state or federal privacy laws. Parties shall at all times comply with D.R.M.C. 20-276.

Confidentiality

Health Plan agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable Colorado State and federal laws, including HIPAA. However, Health Plan has access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this *Agreement* to Health Plan, its agents and employees, Plan Providers, and appropriate governmental agencies, to the extent permitted by HIPAA. Health Plan will not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received Covered Services, unless authorized to do so by the Member. Except as necessary to effectuate this *Agreement*, but only to the extent permitted by HIPAA and applicable Colorado law, Health Plan shall not at any time or in any manner, either directly or indirectly, divulge, disclose or communicate to any person, firm or corporation in any manner whatsoever any information which is not subject to public disclosure, including without limitation the trade secrets of business or entities doing business with the Group, the data contained in any of the data bases of the Group, and other privileged or confidential information. This obligation shall survive the termination of this *Agreement*. Health Plan shall advise its employees, agents and subcontractors, if any, that they are subject to these

confidentiality requirements. Further Health Plan shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

When Rights and Remedies Not Waived

In no event will any payment or other action by the City or Health Plan constitute or be construed to be a waiver by the Parties of any breach of covenant or default that may then exist on the part of the other. No payment, other action, or inaction by the City or Health Plan when any breach or default exists will impair or prejudice any right or remedy available to the Parties with respect to any breach or default. No assent, expressed or implied, to any breach of any term of the Agreement constitutes a waiver of any other breach.

Electronic Signatures and Electronic Records

Health Plan consents to the use of electronic signatures by the City. The Agreement, and any other documents requiring a signature under the Agreement, may be signed electronically by the City in the manner specified by the City. The Parties agree not to deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The Parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

Notices

Notices must be delivered in writing to the addresses listed below, except that

- Health Plan and Group may each change its notice address by giving written notice, via certified mail, to the other.

Notices are to be sent via certified mail and are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to *Group*:

Executive Director
Office Human Resources
201 West Colfax Avenue, Dept. 412
Denver, Colorado 80202

With a copy of any such notice to:

Denver City Attorney's Office
1437 Bannock St., Room 353
Denver, Colorado 80202

Notices from Group to *Health Plan*:

Kaiser Foundation Health Plan of Colorado

2500 South Havana Street
Aurora, CO 80014-1622

Representation Regarding Waiting Periods
By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

Social Security and Tax Identification Numbers
Within 30 – 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this *Agreement*, along with the following:

- The Member's Social Security number
- The tax identification number of the employer of the Subscriber in the Member's Family Unit
- Any other information that Health Plan is required by law to collect

Time Limit on Reporting Membership Changes
Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership additions is the calendar month when Health Plan receives Group's notification of the change plus the previous two months, unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Termination
Group must give Health Plan 30 days prior written notice of Senior Advantage Medicare Plus involuntary membership terminations. An involuntary membership termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage Medicare Plus membership termination notice unless Group specifies a later termination date. For example, if

Health Plan receives a termination notice on March 5 for a Senior Advantage Medicare Plus Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination
If Health Plan receives a disenrollment notice from CMS or membership termination request from the Member, the membership termination date will be in accord with CMS requirements.
The administration of COBRA and State Continuation of Coverage participants will be in accord with applicable Federal and State laws.

Colorado Governmental Immunity Act
The parties hereto understand and agree that the Group is relying upon, and has not waived, the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Immunity Act, C.R.S. §24-10-101 et seq.

Conflict of Interest
The parties agree that no employee of the Group shall have any personal or beneficial interest whatsoever in the services or property described herein and Health Plan further agrees not to hire or contract for the services of any employee or officer of the Group which would be in violation of the Denver Revised Municipal Code Chapter 2, Article IV, Code of Ethics, or Denver City Charter Sections 1.2.9 and 1.2.12.

Severability
It is understood and agreed by the parties hereto that if any part, term, or provision of this *Agreement*, except for the provisions of this *Agreement* requiring prior appropriation of funds and limiting the total amount payable by the Group, is held to be unenforceable for any reason, or in conflict with any law of the State of Colorado, the validity of the remaining portions or provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this *Agreement* did not contain the particular part, term, or provision held to beinvalid.

Survival of Certain Agreement Provisions
The parties understand and agree that all terms and conditions of this *Agreement*, together with the exhibits and attachments hereto, if any, any or all of which, by reasonable implication, contemplate continued performance or compliance beyond the expiration or termination of this *Agreement* (by expiration of the term or otherwise), shall survive such expiration or termination and shall continue to be enforceable as provided herein.

Appropriation Required and Contract Maximum
Notwithstanding any other term, condition, or covenant hereof, it is understood and agreed that any payment obligation of the Group hereunder, whether direct or contingent, shall extend only to funds appropriated by the Denver City Council for the purpose of this *Agreement*, encumbered for the purpose of this *Agreement* and paid into the Treasury of the City and County of Denver. Health Plan acknowledges that (i) the Group does not by this *Agreement* irrevocably pledge present cash reserves for payments in

future fiscal years, and (ii) this *Agreement* is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the Group. The maximum contract amount for the Group's obligations under this *Agreement* and for payment of Premiums, collectively, shall not exceed **NINETY ONE MILLION AND 00/100 DOLLARS ($91,000,000.00)** unless additional appropriation is made by Group and this *Agreement* is amended by the parties pursuant to the **Amendment of *Agreement*** section of this *Agreement*. If Group fails to pay Premiums within the grace period, Health Plan may exercise its rights under the **Termination for Nonpayment** section of this *Agreement* or other applicable rights of Health Plan under this *Agreement*. Only Enrollees for whom Premiums are received by Health Plan are entitled to health care benefits as described in this *Agreement*, and then only for the period for which such payment is received, except as otherwise required by law.

No Employment of workers without authorization to Perform Work under the Agreement.
This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance"). The Health Plan certifies that: at the time of its execution of this *Agreement*, it does not knowingly employ or contract with a worker without authorization who will perform work under this *Agreement*, nor will it knowingly employ or contract with a worker without authorization, and that Health Plan will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this *Agreement*. Health Plan also agrees and represents that Health Plan:

(1) shall not knowingly employ or contract with a worker without authorization to perform work under the *Agreement*;

(2) shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Health Plan that it shall not knowingly employ or contract with a worker without authorization to perform work under the *Agreement*;

(3) has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this *Agreement*, through participation in the E-Verify Program;

(4) is prohibited from using either the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under the *Agreement*, and it is required to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights;

(5) will, if it obtains actual knowledge that a sub Health Plan or subcontractor performing work under the *Agreement* knowingly employs or contracts with a worker without authorization, notify such subconsultant or subcontractor and the City within three (3) days. The Health Plan shall also terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with a worker without authorization, unless during such three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with a worker without authorization, and;

(6) will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S., or the City Auditor, under authority of D.R.M.C. 20-90.3.

Health Plan is liable for any violations as provided in the Certification Ordinance. If Health Plan violates any provision of this section or the Certification Ordinance, the City may terminate this *Agreement* for a breach of the *Agreement*. If the *Agreement* is so terminated, the Health plan shall be liable for actual and consequential damages to the City. Any such termination of a contract due to a violation of this section or the Certification Ordinance may also, at the discretion of the City, constitute grounds for disqualifying Health Plan from submitting bids or proposals for future contracts with the City.

***Agreement* as Complete Integration-Amendments**

The *Agreement* is the complete integration of all understandings between the Parties as to the subject matter of the *Agreement*. No prior, contemporaneous or subsequent addition, deletion, or other modification has any force or effect, unless embodied in the *Agreement* in writing. No oral representation by any officer or employee of the City at variance with the terms of the *Agreement* or any written amendment to the *Agreement* will have any force or effect or bind the City.

Use, Possession or Sale of Alcohol or Drugs

Health Plan shall cooperate and comply with the provisions of Executive Order 94 and its Attachment A concerning the use, possession or sale of alcohol or drugs. Violation of these provisions or refusal to cooperate with implementation of the policy can result in contract personnel being barred from City facilities and from participating in City operations.

Grant of Limited License to Use Logo.

The City hereby grants to Health Plan, subject to the terms and conditions set forth herein, a non-exclusive, nontransferable limited license, to use the "Denver D" logo ("**Denver Logo**") during the Term of this *Agreement*. Health Plan shall fully coordinate all logo use under this Agreement with the Denver Marketing Office (www.denvergov.org/brandcenter, (720) 865-2300, marketing@denvergov.org), or otherwise as directed by the City. The use of the Denver Logo is limited to display on the website to be created by Health Plan pursuant to this *Agreement* and for the purpose of identification only.

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[SIGNATURE BLOCKS ON NEXT PAGE]

Contract Control Number: CSAHR-202056747-00
Contractor Name: KAISER PERMANENTE

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: _____

_____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: _____

REGISTERED AND COUNTERSIGNED:

By: _____

By: _____

Contract Control Number: CSAHR-202056747-00
Contractor Name: KAISER PERMANENTE

By: _____

Name: Michael S. Ramseier
(please print)

Title: Regional President - Colorado
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A – Summary List of Attached Exhibits:

1. **Exhibit A-1**: City and County of Denver Civilian DHMO Evidence of Coverage ("**EOC**").
2. **Exhibit A-2**: City and County of Denver HDHP EOC.
3. **Exhibit A-3**: City and County of Denver Police DHMO EOC.
4. **Exhibit A-4**: City and County of Denver Police HDHP EOC.
5. **Exhibit A-5**: City and County of Denver Fire POS65 – Silver HMO EOC.
6. **Exhibit A-6**: City and County of Denver Fire POS65 – Gold HMO EOC.
7. **Exhibit A-7**: City and County of Denver Fire (74) HMO RET EOC.
8. **Exhibit A-8**: City and County of Denver Fire (74) HMO EOC.
9. **Exhibit A-9**: City and County of Denver Fire (74) HDHP 1500 EOC.
10. **Exhibit A-10**: City and County of Denver Fire (74) POS 300 EOC.
11. **Exhibit A-11**: City and County of Denver Fire (74) PPO 300 Certificate of Insurance.
12. **Exhibit A-12**: City and County of Denver Fire (74) POS 300 Certificate of Insurance.
13. **Exhibit A-13**: City and County of Denver Civilian (75) Ratesheet.
14. **Exhibit A-14**: City and County of Denver Police (68) Ratesheet.
15. **Exhibit A-15**: City and County of Denver Fire (74) Ratesheet.
16. **Exhibit A-16**: 2021 Performance Guarantees Agreement for Civilian Coverage.
17. **Exhibit A-17**: 2021 Performance Guarantees Agreement for Police Coverage.
18. **Exhibit A-18**: 2021 Performance Guarantees Agreement for Fire Coverage.

EXHIBIT A-1
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-1: City and County of Denver Civilian DHMO Evidence of Coverage ("**EOC**").

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

kp.org

KAISER PERMANENTE®

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

CITY AND COUNTY OF DENVER

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean: career service employees as defined in section 9.1.1(e) of the charter, appointed charter officers as defined in section 9.2.1(B) of the charter, and elected charter officers as defined in section 9.2.1 (A) of the charter. The definition of eligible employee shall not include:
   a) Part-time employees who are regularly scheduled to work less than twenty (20) hours per week;
   b) Members of the classified service of the police and fire departments; and,
   c) Persons occupying or employed in on-call (Eligible if employed for 12 months and averaging at least 30 hours per week in accordance with the Patient Protection and Affordable Care Act), temporary, seasonal, or contract positions, or positions in which the incumbent is paid according to the community rate schedule.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

(Ord. No. 959-05, § 1, 12-19-05; Ord. No. 661-12, § 3, 12-26-12; Ord. No. 489-14, § 1, 9-8-14; Ord. No. 763-17, § 1, 8-7-17)

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

A. The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies. Covered Services may or may not be subject to the medical Deductible. It depends on the plan your Group has purchased.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

1. For covered Services that **ARE** subject to the medical Deductible:

   a. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.

   b. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").

   c. Your applicable Copayment, Coinsurance, and medical Deductible may apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").

2. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance."

B. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply only to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

1. For prescription drugs that **ARE** subject to the pharmacy Deductible:

   a. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.

   b. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements").

   c. If your Group purchased a plan with a pharmacy Deductible, payments made for prescription drugs will be applied only to the pharmacy Deductible. Your pharmacy Deductible does not apply to the medical Deductible and accumulates separately from the medical Deductible.

   d. Your applicable Copayment, Coinsurance, and/or pharmacy Deductible may not apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").

2. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your Deductible(s) may apply to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Deductible(s) and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your Deductible(s) and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org.**

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

EMBEDDED Medical Deductible *(Applies to Out-of-Pocket Maximum)*	$500/Individual per Accumulation Period $1,000/Family per Accumulation Period

An Embedded Medical Deductible means:

- Each individual family Member has his or her own medical Deductible.
- If a family Member reaches his or her individual medical Deductible before the family medical Deductible is met, he or she will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
- After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period. This is true even for family Members who have not met their individual medical Deductible.

Out-of-Pocket Maximum

EMBEDDED OPM	$4,500/Individual per Accumulation Period $9,000/Family per Accumulation Period

An Embedded OPM means:

- Each individual family Member has his or her own OPM.
- If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.
- After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: 20% Coinsurance
Specialty care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Consultations with clinical pharmacists *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: 20% Coinsurance
Allergy evaluation and testing	
• Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge
• Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit
Allergy injections *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Covered Services received during a visit: 20% Coinsurance An additional charge may apply for allergy serum.
Gynecology care visits Visit: *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $50 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Office-administered drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Travel immunizations *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, video visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Outpatient Hospital and Surgical Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Copayment not subject to medical Deductible, Coinsurance subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Ambulatory surgical center: $500 Copayment each surgery Outpatient hospital: 20% Coinsurance
Outpatient hospital Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Inpatient professional Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Bariatric Surgery	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	50% Coinsurance

Dental Services following Accidental Injury	**You Pay**
(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

• Peak flow meters *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see "X-ray, Laboratory and X-ray Special Procedures" for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge Covered Services received during a visit: 20% Coinsurance
Urgent care outside Service Area *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge Covered Services received during a visit: 20% Coinsurance

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	You Pay
Training in self-care and preventive care *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *Exam: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Exam: No Charge Covered Services received during a visit: No additional charge
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *Exam: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Exam: $75 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Hearing aids for Members up to age 18 *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Fitting and Recheck visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Hearing aids for Members age 18 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and Recheck visits *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge including partial hospitalization Covered services received during a Visit: 20% Coinsurance
Outpatient group therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: 20% Coinsurance

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area.	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and sudstance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $20 Copayment Other Services received during an office visit: Not Covered Preventive Immunizations: No Charge
Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment
Outpatient prescription drugs *(Not subject to pharmacy Deductible)*	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Over the counter (OTC) items: *(Federally mandated over the counter items)* *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)* o Tobacco cessation drugs *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	No Charge No Charge No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	**You Pay**
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance; Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational and speech therapy visits	
• Habilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Up to 20 visits per therapy per Accumulation Period
• Rehabilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Up to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Pulmonary rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs *(Prescriptions are not subject to the medical Deductible and are subject to the pharmacy Deductible except as otherwise listed in this "Prescription Drugs, Supplies and Supplements" section.*	
• Pharmacy Deductible *(Applies to Out-of-Pocket Maximum)*	Not Applicable
• Copayment/Coinsurance (except as listed below) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$10 Generic/$35 Brand name/$60 Non-Preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to medical or pharmacy Deductible)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Up to $100 per drug dispensed
• Tobacco cessation drugs *(Not subject to medical or pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$20 Generic/$70 Brand name/$120 Non-Preferred Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam *(See "Office Services" or "Laboratory Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Inpatient professional Services for medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance including partial hospitalization Covered Services received during a visit: No additional charge
Outpatient group therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: No additional charge
Residential rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance per inpatient admission

Transplant Services	You Pay
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Test: No Charge
• Members age 19 and over *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Test: No Charge
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit Test: 20% Coinsurance
• Members age 19 and over *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit Test: 20% Coinsurance
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs")*	$250 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.

   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**
Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)," will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, and/or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions

   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:
1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Deductibles, Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)". For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Services performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)".

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:
   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC.

   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

   d. Pulmonary Rehabilitation

Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies.
   ii. disposable syringes for the administration of insulin.
   iii. glucose test strips.
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices.**

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually

by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;

e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. is the subject of a current new drug or new device application on file with the FDA; or
      iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. the Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

   d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we

may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

   iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering the **non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons

who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting Benefits/Coverage (What is Covered) under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to Benefits/Coverage (What is Covered) under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health

plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

N. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Q. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;

3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Breast prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to Benefits/Coverage (What is Covered) end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination/Nonrenewal/Continuation" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:

a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or Benefits/Coverage (What is Covered).

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to Benefits/Coverage (What is Covered) cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:
1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:
   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative

If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal

When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15-days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will

ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for

the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right

to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

   c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions
   i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
   ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
   iii. Non-medical items such as sauna baths or elevators.
   iv. Exercise or hygiene equipment.
   v. Comfort, convenience, or luxury equipment or features.
   vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
   *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
   vii. Replacement of lost or stolen equipment.
   viii. Repairs, adjustments, or replacements necessitated by misuse.
   ix. More than one piece of DME serving essentially the same function, except for replacements.
   x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
   Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

   b. Prosthetic Devices Exclusions
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost or stolen prosthetic devices.
      vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
   Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

HEAR0AC

HEARING AID CREDIT

1. Coverage
   For Members age 18 and over, a credit per ear, which can be applied toward the purchase of a hearing aid (including dispensing fees associated with the hearing aid purchase), is provided as shown on the "Schedule of Benefits (Who Pays What)" when prescribed

by, and obtained from, a Plan Provider. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound.

The full per ear credit must be used at the initial point of sale. Any credit balance remaining after the initial point of sale is forfeited.

2. Hearing Aid Exclusions
   a. Replacement parts for the repair of a hearing aid.
   b. Replacement of lost or broken hearing aids.
   c. Accessory parts and routine maintenance.
   d. Batteries.

This rider amends the EOC to provide coverage for hearing aids. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

HEAR0AC (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations
   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions
   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
   f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.

- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:

a. Plan Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:

a. Drugs for which a prescription is required by law.
b. Insulin.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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CITY AND COUNTY OF DENVER

Important plan information

000000075 075 EM1C HP DG GP 52_21 [May.12,2021] OVC07HOSPCBBLDN7MHOPC4SPVC4VOPT--CDOPD9HEARVHEMER2ZPV1UAFTRZYACUMCLALG1QALGTNAAMB0CAUTB9GCDIPZ2CDRR39CHIR2ICMPL--COIN15CRCS0KDED0MDEN--DIAL2ZDMEB1ADMES1KDPP--DUMYDMEMPHA8EPOT--EXAB--FAM2UFRST--GRP0OGYN2AHC0VHCSS0JHH2ZHOOP1OHOS20LHRA--INFT1GLAB5QMHBINAMHBONAMHIP13OPM4NOVC20VOXYG0YPNMT1OPP--REHB05REOPU1SGOP4PSNF2DSNKR--STU92TABS8CTRAN12TRGNCCTRVL--VADD--WLCH0YXPRO4IXRAY9DCDOPD9MHOPC4HEARVHSPVC4VOVC307RX04N7DOMP01GREX01GRFD02OAD6MOAS6MSV03WORAN

EXHIBIT A-2
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-2: City and County of Denver HDHP EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. This EOC is for your Group's 2021 contract year.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "Out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

The health care coverage described in this EOC has been designed to be a High Deductible Health Plan (HDHP) compatible for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified High Deductible Health Plan.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

CITY AND COUNTY OF DENVER

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean: career service employees as defined in section 9.1.1(e) of the charter, appointed charter officers as defined in section 9.2.1(B) of the charter, and elected charter officers as defined in section 9.2.1 (A) of the charter. The definition of eligible employee shall not include:
   a) Part-time employees who are regularly scheduled to work less than twenty (20) hours per week;
   b) Members of the classified service of the police and fire departments; and,
   c) Persons occupying or employed in on-call (Eligible if employed for 12 months and averaging at least 30 hours per week in accordance with the Patient Protection and Affordable Care Act), temporary, seasonal, or contract positions, or positions in which the incumbent is paid according to the community rate schedule.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

(Ord. No. 959-05, § 1, 12-19-05; Ord. No. 661-12, § 3, 12-26-12; Ord. No. 489-14, § 1, 9-8-14; Ord. No. 763-17, § 1, 8-7-17)

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

A. For covered Services that **ARE** subject to the medical Deductible:

   1. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.

   2. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").

   3. Your applicable Copayment and Coinsurance may apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your medical Deductible applies to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

   1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your medical Deductible and/or OPM amounts.

For more information about your medical Deductible or OPM amounts, please call **Member Services** or go to **kp.org.**

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

AGGREGATE Medical Deductible *(Applies to Out-of-Pocket Maximum)*	$1,450/Individual per Accumulation Period $2,900/Family per Accumulation Period

An Aggregate Medical Deductible means:

• If you are the only person covered on your plan, the individual Medical Deductible amount applies. After the individual medical Deductible is met, the Member will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.

• If there are two or more family Members on your plan, the individual Medical Deductible amount does not apply. The entire family Medical Deductible must be met before Copayment or Coinsurance is applied for any individual family Member. No one in the family is considered to have met the Deductible until the entire family Deductible is met.

Out-of-Pocket Maximum

AGGREGATE OPM	$2,900/Individual per Accumulation Period $5,800/Family per Accumulation Period

An Aggregate OPM means:

• If you are the only person covered on your plan, the individual OPM amount applies. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.

• If there are two or more family Members on your plan, the individual OPM amount does not apply. The family OPM amount applies to the entire family as a whole. The entire family medical OPM amount must be met before any covered family Member will no longer pay Copayments or Coinsurance for covered Services. No one in the family is considered to have met the OPM until the entire family OPM is met.

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Consultations with clinical pharmacists *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Allergy evaluation and testing	
• Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance
• Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance
Allergy injections *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Gynecology care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Office-administered drugs (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
• Travel immunizations *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, video visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	

Outpatient surgery at Plan Facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Ambulatory surgical center: 10% Coinsurance Outpatient hospital: 20% Coinsurance
Outpatient hospital Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Inpatient professional Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Bariatric Surgery	**You Pay**
(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dental Services following Accidental Injury	**You Pay**
(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" medical Deductible and Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Urgent care outside Service Area *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Hearing aids for Members up to age 18 (*Subject to medical Deductible;* Applies to Out-of-Pocket Maximum)	20% Coinsurance
• Fitting and recheck visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Hearing aids for Members age 18 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services prescribed by a Plan Provider (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Hospice care for terminally ill patients (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance including partial hospitalization
Outpatient group therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: 20% Coinsurance Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: 20% Coinsurance
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Over the counter (OTC) items: *(Federally mandated over the counter items)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Tobacco cessation drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge No Charge No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance; Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational and speech therapy visits	
• Habilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Pulmonary rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the medical Deductible and apply to the Out-of-Pocket Maximum except as otherwise listed in this "Prescription Drugs, Supplies, and Supplements" section.)*	$10 Generic/$35 Brand name/$60 Non-Preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Pharmacy Deductible	Not Applicable
• Infertility drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to medical or pharmacy Deductible)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to medical or pharmacy Deducible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$20 Generic/$70 Brand name/$120 Non-Preferred Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum*) • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam *(See "Office Services" or "Laboratory Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Intrauterine insemination (IUI) *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
In Vitro Fertilization (IVF) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance Limited to 100 days per Accumulation Period

Subustance Use Disorder Services	You Pay
Inpatient medical detoxification (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Inpatient professional Services for medical detoxification (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance including partial hospitalization
Outpatient group therapy (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Residential rehabilitation (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance per inpatient admission

Transplant Services	You Pay
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care"for medical Deductible and Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
• Members age 19 and over *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
• Members age 19 and over *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Not subject to medical Deductible;* Does not apply to Out-of-Pocket Maximum)	Not Covered
• Members age 19 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Diagnostic X-ray Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Therapeutic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*) • Diagnostic procedures include administered drugs. • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs")*	20% Coinsurance

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week	
CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health	
CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services	
CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services	
CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

4. Health Savings Account Eligibility

Enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be: (a) covered by another health coverage plan (for example, through your spouse's employer) that is not also an HSA-compatible health plan, with certain exceptions; (b) enrolled in Medicare; or (c) able to be claimed as a Dependent on another person's tax return. Consult your tax advisor for more information about your eligibility for an HSA.

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date.

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
      For existing Subscribers:
      i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
      ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

   b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
      For existing Subscribers:
      i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
      ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

   c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment
   You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling
   You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services**

if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.

11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.
    - Drugs (including Biologics and Biosimilars) and injectables;
    - Radioactive materials used for therapeutic purposes;
    - Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
    - Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and
4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.
   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.
2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

b. Prosthetic Devices Exclusions
   i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
   ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are subject to the Deductible and apply toward the Out-of-Pocket Maximum. EIS are not subject to any Copayments or Coinsurance.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. **Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)**
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would

have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area
There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."
   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. After your Deductible has been met, we also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational and speech therapy Coinsurance.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

In any Accumulation Period, you must pay full Charges for all drugs until you meet your Deductible. After you meet your Deductible, you pay the applicable Copayment or Coinsurance for these drugs for the rest of the Accumulation Period, subject to the annual Out-of-Pocket Maximum limits.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day

supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs

Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements

We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories

Prescribed supplies and accessories, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

i. home glucose monitoring supplies.
ii. disposable syringes for the administration of insulin.
iii. glucose test strips.
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage

   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion

   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services

   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation

   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services

   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion

   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage

   Transplants are covered on a limited basis as follows:

   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

b. Non-human and artificial organs and their implantation are excluded.

c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
a. Eyeglass lenses and frames.
b. Contact lenses.
c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment.

This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services**
    a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:

       i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
       ii. Is the subject of a current new drug or new device application on file with the FDA; or
       iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
       iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
       v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
       vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
       vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
       viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:

i. The Member's medical records; and
ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.

13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased supplemental coverage.

14. **Intermediate Care.** Care in an intermediate care facility.

15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.

17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.

20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.

21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

22. **Weight Management Facilities.** Services received in a weight management facility.

23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

    When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be

reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:
   i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

   ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
      2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

   B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
      2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
      3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
      4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
         - The **Plan** covering the **Custodial parent**;
         - The **Plan** covering the spouse of the **Custodial parent**;
         - The **Plan** covering the **non-custodial parent**; and then
         - The **Plan** covering the spouse of the **non-custodial parent**.

   C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

   iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

   iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

   v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

   vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the

Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any or from other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your

attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy

In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504).

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507).

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department**. To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

N. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Q. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan

Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)
   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:
   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance
You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if

you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

      If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

      We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

      We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

      If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

      If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

   b. Non-Urgent Pre-Service Appeal

      Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2)

your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.

Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim

Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your

medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision, if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not

provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal

claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

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

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:

- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126,

80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

   c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions
   i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
   ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
   iii. Non-medical items such as sauna baths or elevators.
   iv. Exercise or hygiene equipment.
   v. Comfort, convenience, or luxury equipment or features.
   vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
   *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
   vii. Replacement of lost or stolen equipment.
   viii. Repairs, adjustments, or replacements necessitated by misuse.
   ix. More than one piece of DME serving essentially the same function, except for replacements.
   x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
   Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

   b. Prosthetic Devices Exclusions
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost or stolen prosthetic devices.
      vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
   Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible,

Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:

a. Home glucose monitoring supplies.
b. Glucose test strips.
c. Acetone test tablets.
d. Nitrate urine test strips for pediatric patients.
e. Disposable syringes for the administration of insulin.

Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:
a. Plan Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:
a. Drugs for which a prescription is required by law.
b. Insulin.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.

o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

NOTES

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Kaiser Foundation Health Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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CITY AND COUNTY OF DENVER

Important plan information

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EXHIBIT A-3
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-3: City and County of Denver Police DHMO EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

kp.org

KAISER PERMANENTE®

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER POLICE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the police department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

A. The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies. Covered Services may or may not be subject to the medical Deductible. It depends on the plan your Group has purchased.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

1. For covered Services that **ARE** subject to the medical Deductible:

   a. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.

   b. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").

   c. Your applicable Copayment, Coinsurance, and medical Deductible may apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").

2. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance."

B. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply only to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

1. For prescription drugs that **ARE** subject to the pharmacy Deductible:

   a. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.

   b. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements").

   c. If your Group purchased a plan with a pharmacy Deductible, payments made for prescription drugs will be applied only to the pharmacy Deductible. Your pharmacy Deductible does not apply to the medical Deductible and accumulates separately from the medical Deductible.

   d. Your applicable Copayment, Coinsurance, and/or pharmacy Deductible may not apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").

2. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your Deductible(s) may apply to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Deductible(s) and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your Deductible(s) and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org.**

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

EMBEDDED Medical Deductible *(Applies to Out-of-Pocket Maximum)*	$500/Individual per Accumulation Period $1,000/Family per Accumulation Period

An Embedded Medical Deductible means:

- Each individual family Member has his or her own medical Deductible.
- If a family Member reaches his or her individual medical Deductible before the family medical Deductible is met, he or she will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
- After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period. This is true even for family Members who have not met their individual medical Deductible.

Out-of-Pocket Maximum

EMBEDDED OPM	$4,500/Individual per Accumulation Period $9,000/Family per Accumulation Period

An Embedded OPM means:

- Each individual family Member has his or her own OPM.
- If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.
- After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: 20% Coinsurance
Specialty care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Consultations with clinical pharmacists *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: 20% Coinsurance
Allergy evaluation and testing	
• Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge
• Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit
Allergy injections *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Covered Services received during a visit: 20% Coinsurance An additional charge may apply for allergy serum.
Gynecology care visits Visit: *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $50 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Office-administered drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Travel immunizations *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, video visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Outpatient Hospital and Surgical Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Copayment not subject to medical Deductible, Coinsurance subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Ambulatory surgical center: $500 Copayment each surgery Outpatient hospital: 20% Coinsurance
Outpatient hospital Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Inpatient professional Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Bariatric Surgery	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	50% Coinsurance

Dental Services following Accidental Injury	**You Pay**
(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

• Peak flow meters *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see "X-ray, Laboratory and X-ray Special Procedures" for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge Covered Services received during a visit: 20% Coinsurance
Urgent care outside Service Area *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge Covered Services received during a visit: 20% Coinsurance

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	You Pay
Training in self-care and preventive care *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *Exam: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Exam: No Charge Covered Services received during a visit: No additional charge
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *Exam: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Exam: $75 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Hearing aids for Members up to age 18 *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Fitting and Recheck visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Hearing aids for Members age 18 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and Recheck visits *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge including partial hospitalization Covered services received during a Visit: 20% Coinsurance
Outpatient group therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: 20% Coinsurance

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area.	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and sudstance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $20 Copayment Other Services received during an office visit: Not Covered Preventive Immunizations: No Charge
Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment
Outpatient prescription drugs *(Not subject to pharmacy Deductible)*	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Over the counter (OTC) items: *(Federally mandated over the counter items)* *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)* o Tobacco cessation drugs *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	No Charge No Charge No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	**You Pay**
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance; Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational and speech therapy visits	
• Habilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Up to 20 visits per therapy per Accumulation Period
• Rehabilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Up to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Pulmonary rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs *(Prescriptions are not subject to the medical Deductible and are subject to the pharmacy Deductible except as otherwise listed in this "Prescription Drugs, Supplies and Supplements" section.*	
• Pharmacy Deductible *(Applies to Out-of-Pocket Maximum)*	Not Applicable
• Copayment/Coinsurance (except as listed below) *(Not subject to medical Deductible; Not subject to medical Deductible)*	$10 Generic/$35 Brand name/$60 Non-Preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to medical or pharmacy Deductible)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Up to $100 per drug dispensed
• Tobacco cessation drugs *(Not subject to medical or pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$20 Generic/$70 Brand name/$120 Non-Preferred Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam *(See "Office Services" or "Laboratory Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Inpatient professional Services for medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance including partial hospitalization Covered Services received during a visit: No additional charge
Outpatient group therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Covered Services received during a visit: No additional charge
Residential rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance per inpatient admission

Transplant Services	You Pay
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Test: No Charge
• Members age 19 and over *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: No Charge Test: No Charge
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit Test: 20% Coinsurance
• Members age 19 and over *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $75 Copayment each visit Test: 20% Coinsurance
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs")*	$250 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.

   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**
Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)," will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, and/or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions

   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:
1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Deductibles, Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)". For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Services performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)".

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:
   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC.

   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

   d. Pulmonary Rehabilitation

Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies.
   ii. disposable syringes for the administration of insulin.
   iii. glucose test strips.
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices.**

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually

by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;

e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. is the subject of a current new drug or new device application on file with the FDA; or
      iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. the Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

   d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we

may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

   iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering the **non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons

who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting Benefits/Coverage (What is Covered) under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to Benefits/Coverage (What is Covered) under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health

plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

N. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Q. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;

3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Breast prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to Benefits/Coverage (What is Covered) end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination/Nonrenewal/Continuation" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:

a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or Benefits/Coverage (What is Covered).

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to Benefits/Coverage (What is Covered) cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:
1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:
   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative

If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal

When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15-days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will

ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for

the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right

to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

HEAR0AC

HEARING AID CREDIT

1. Coverage
   For Members age 18 and over, a credit per ear, which can be applied toward the purchase of a hearing aid (including dispensing fees associated with the hearing aid purchase), is provided as shown on the "Schedule of Benefits (Who Pays What)" when prescribed by, and obtained from, a Plan Provider. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound.

   The full per ear credit must be used at the initial point of sale. Any credit balance remaining after the initial point of sale is forfeited.

2. Hearing Aid Exclusions
   a. Replacement parts for the repair of a hearing aid.
   b. Replacement of lost or broken hearing aids.
   c. Accessory parts and routine maintenance.
   d. Batteries.

This rider amends the EOC to provide coverage for hearing aids. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

HEAR0AC (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations
   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions
   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
   f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage
   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain

specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

Non-Formulary Drug Exception Process:
You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

Prescribed supplies and accessories include, but may not be limited to:
a. Home glucose monitoring supplies.
b. Glucose test strips.
c. Acetone test tablets.
d. Nitrate urine test strips for pediatric patients.
e. Disposable syringes for the administration of insulin.

Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:
a. Plan Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:
a. Drugs for which a prescription is required by law.
b. Insulin.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.

g. Drugs to enhance athletic performance.
h. Drugs available over the counter and by prescription for the same strength.
i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
j. Drugs for the treatment of weight control.
k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
m. Drugs administered during a medical office visit.
n. Medical Foods and Medical Devices.
o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

57927 **********AUTO**5-DIGIT 80227

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DENVER POLICE DEPARTMENT

Important plan information

000000068 085 EM1C HP DG GP 52_21 [Mar.17,2021] OVC07HOSPCBBLDN7MHOPC4SPVC4VOPT--CDOPD9HEARVHEMER2ZPV1UAFTRZYACUMCLALG1QALGTNAAMB2ZAUTB9GCDIPZ2CDRR39CHIR2ICMPL--COIN15CRCS0KDED0MDENNADIAL2ZDMEB1ADMES1KDPP--DUMYDMEMPHA8EPOT--EXAB--FAM2UFRST--GRP0OGYN2AHC0VHCSS0JHH2ZHOOP1OHOS20LHRA--INFT1GLAB5QMHBINAMHBONAMHIP13OPM4NOVC20VOXYG0YPNMT1OPP--REHB05REOPU1SGOP4PSNF2DSNKR--STU92TABS8CTRAN12TRGNCCTRVL--VADD--WLCH0YXPRO4IXRAY9DCDOPD9MHOPC4HEARVHSPVC4VOVC307RX04N7DOMP01GREX01GRFD02OAD6MOAS6MSRDC05SV03WORAN

EXHIBIT A-4
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-4: City and County of Denver Police HDHP EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. This EOC is for your Group's 2021 contract year.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "Out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

The health care coverage described in this EOC has been designed to be a High Deductible Health Plan (HDHP) compatible for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified High Deductible Health Plan.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER POLICE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the police department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

A. For covered Services that **ARE** subject to the medical Deductible:

   1. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.

   2. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").

   3. Your applicable Copayment and Coinsurance may apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your medical Deductible applies to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

   1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your medical Deductible and/or OPM amounts.

For more information about your medical Deductible or OPM amounts, please call **Member Services** or go to **kp.org.**

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

AGGREGATE Medical Deductible *(Applies to Out-of-Pocket Maximum)*	$1,450/Individual per Accumulation Period $2,900/Family per Accumulation Period

An Aggregate Medical Deductible means:

• If you are the only person covered on your plan, the individual Medical Deductible amount applies. After the individual medical Deductible is met, the Member will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.

• If there are two or more family Members on your plan, the individual Medical Deductible amount does not apply. The entire family Medical Deductible must be met before Copayment or Coinsurance is applied for any individual family Member. No one in the family is considered to have met the Deductible until the entire family Deductible is met.

Out-of-Pocket Maximum

AGGREGATE OPM	$2,900/Individual per Accumulation Period $5,800/Family per Accumulation Period

An Aggregate OPM means:

• If you are the only person covered on your plan, the individual OPM amount applies. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.

• If there are two or more family Members on your plan, the individual OPM amount does not apply. The family OPM amount applies to the entire family as a whole. The entire family medical OPM amount must be met before any covered family Member will no longer pay Copayments or Coinsurance for covered Services. No one in the family is considered to have met the OPM until the entire family OPM is met.

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Consultations with clinical pharmacists *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Allergy evaluation and testing	
• Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance
• Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance
Allergy injections *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Gynecology care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Office-administered drugs (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
• Travel immunizations *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, video visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	

Outpatient surgery at Plan Facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Ambulatory surgical center: 10% Coinsurance Outpatient hospital: 20% Coinsurance
Outpatient hospital Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Inpatient professional Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Bariatric Surgery	**You Pay**
(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dental Services following Accidental Injury	**You Pay**
(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" medical Deductible and Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Urgent care outside Service Area *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Hearing aids for Members up to age 18 (*Subject to medical Deductible;* Applies to Out-of-Pocket Maximum)	20% Coinsurance
• Fitting and recheck visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Hearing aids for Members age 18 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services prescribed by a Plan Provider (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Hospice care for terminally ill patients (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance including partial hospitalization
Outpatient group therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: 20% Coinsurance Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: 20% Coinsurance
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Over the counter (OTC) items: *(Federally mandated over the counter items)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Tobacco cessation drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge No Charge No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance; Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational and speech therapy visits	
• Habilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Pulmonary rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the medical Deductible and apply to the Out-of-Pocket Maximum except as otherwise listed in this "Prescription Drugs, Supplies, and Supplements" section.)*	$10 Generic/$35 Brand name/$60 Non-Preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Pharmacy Deductible	Not Applicable
• Infertility drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to medical or pharmacy Deductible)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to medical or pharmacy Deducible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$20 Generic/$70 Brand name/$120 Non-Preferred Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum*) • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam *(See "Office Services" or "Laboratory Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Intrauterine insemination (IUI) *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
In Vitro Fertilization (IVF) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance Limited to 100 days per Accumulation Period

Subustance Use Disorder Services	You Pay
Inpatient medical detoxification (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Inpatient professional Services for medical detoxification (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance including partial hospitalization
Outpatient group therapy (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Residential rehabilitation (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance per inpatient admission

Transplant Services	You Pay
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care"for medical Deductible and Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
• Members age 19 and over *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
• Members age 19 and over *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Not subject to medical Deductible;* Does not apply to Out-of-Pocket Maximum)	Not Covered
• Members age 19 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Diagnostic X-ray Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Therapeutic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*) • Diagnostic procedures include administered drugs. • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs")*	20% Coinsurance

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week	
CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health	
CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services	
CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services	
CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

4. Health Savings Account Eligibility

Enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be: (a) covered by another health coverage plan (for example, through your spouse's employer) that is not also an HSA-compatible health plan, with certain exceptions; (b) enrolled in Medicare; or (c) able to be claimed as a Dependent on another person's tax return. Consult your tax advisor for more information about your eligibility for an HSA.

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date.

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
      For existing Subscribers:
      i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
      ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

   b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
      For existing Subscribers:
      i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
      ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

   c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment
   You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling
   You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services**

if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.

11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.
    - Drugs (including Biologics and Biosimilars) and injectables;
    - Radioactive materials used for therapeutic purposes;
    - Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
    - Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and
4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.
   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.
2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

b. Prosthetic Devices Exclusions
   i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
   ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are subject to the Deductible and apply toward the Out-of-Pocket Maximum. EIS are not subject to any Copayments or Coinsurance.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. **Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)**
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would

have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area
There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."
   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. After your Deductible has been met, we also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational and speech therapy Coinsurance.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

In any Accumulation Period, you must pay full Charges for all drugs until you meet your Deductible. After you meet your Deductible, you pay the applicable Copayment or Coinsurance for these drugs for the rest of the Accumulation Period, subject to the annual Out-of-Pocket Maximum limits.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day

supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs

Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements

We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories

Prescribed supplies and accessories, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

i. home glucose monitoring supplies.
ii. disposable syringes for the administration of insulin.
iii. glucose test strips.
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage

   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion

   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services

   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation

   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services

   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion

   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage

   Transplants are covered on a limited basis as follows:

   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

b. Non-human and artificial organs and their implantation are excluded.

c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
a. Eyeglass lenses and frames.
b. Contact lenses.
c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment.

This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services**
    a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:

       i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
       ii. Is the subject of a current new drug or new device application on file with the FDA; or
       iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
       iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
       v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
       vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
       vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
       viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:

i. The Member's medical records; and
ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.

13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased supplemental coverage.

14. **Intermediate Care.** Care in an intermediate care facility.

15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.

17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.

20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.

21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

22. **Weight Management Facilities.** Services received in a weight management facility.

23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

    When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be

reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:
   i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

   ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
      2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

   B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
      2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
      3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
      4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
         - The **Plan** covering the **Custodial parent**;
         - The **Plan** covering the spouse of the **Custodial parent**;
         - The **Plan** covering the **non-custodial parent**; and then
         - The **Plan** covering the spouse of the **non-custodial parent**.

   C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

   iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

   iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

   v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

   vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the

Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any or from other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your

attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy

In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504).

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507).

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department**. To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

N. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Q. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan

Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)
   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:
   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance
You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if

you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

      If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

      We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

      We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

      If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

      If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

   b. Non-Urgent Pre-Service Appeal

      Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2)

your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.

Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim

Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your

medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision, if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not

provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal

claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

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

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:

- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126,

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Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

Non-Formulary Drug Exception Process:
You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

Prescribed supplies and accessories include, but may not be limited to:
a. Home glucose monitoring supplies.
b. Glucose test strips.
c. Acetone test tablets.
d. Nitrate urine test strips for pediatric patients.
e. Disposable syringes for the administration of insulin.

Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:
a. Plan Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:
a. Drugs for which a prescription is required by law.
b. Insulin.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.

d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
e. Any drugs listed as not covered in the “Schedule of Benefits (Who Pays What)”.
f. Drugs to shorten the length of the common cold.
g. Drugs to enhance athletic performance.
h. Drugs available over the counter and by prescription for the same strength.
i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
j. Drugs for the treatment of weight control.
k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
m. Drugs administered during a medical office visit.
n. Medical Foods and Medical Devices.
o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

NOTES

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Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER POLICE DEPARTMENT

Important plan information

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EXHIBIT A-5
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-5: City and County of Denver Fire POS65 – Silver HMO EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

kp.org

KAISER PERMANENTE®

KAISER PERMANENTE®

Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the fire department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit An additional charge may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance (prostate cancer drugs only) All other office-administered drugs @ No Charge
• Travel immunizations *(Applies to Out-of-Pocket Maximum)*	No Charge
Virtual Care Services	
• Email o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$300 Copayment each surgery

Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $300

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	**You Pay**
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

Dental Services following Accidental Injury	**You Pay**
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Applies to Out-of-Pocket Maximum)	$30 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies to Out-of-Pocket Maximum)*	No Charge
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see “X-ray, Laboratory, and X-ray Special Procedures” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See “Outpatient Hospital and Surgical Services” for Out-of-Pocket Maximum information).*	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services:* (*Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations:* (*Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $20 Copayment Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
o Over the counter (OTC) items *(Federally mandated over the counter items)* *(Applies to Out-of-Pocket Maximum)*	No Charge
o Tobacco cessation drugs *(Applies to Out-of-Pocket Maximum)*	No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Applied Behavioral Services	

• Applied Behavior Analysis (ABA) (*Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit

Prescription Drugs, Supplies, and Supplements	**You Pay**
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand Contraceptive drugs at No Charge Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Applies to Out-of-Pocket Maximum)* • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission

Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per inpatient admission

Transplant Services	**You Pay**
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll-free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:
   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."
   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."
   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies;
   ii. disposable syringes for the administration of insulin;
   iii. glucose test strips;
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure

is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;

d. Antiseptics;
e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing

covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate

arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the “Schedule of Benefits (Who Pays What).” Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado’s network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

M. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or

b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination,

and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if

circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the

date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

FIRST RESPONDER BENEFIT

Coverage

Your Group has purchased additional coverage for employees who qualify as first responders. The following screening tests and medical Services are covered at no charge* when performed by a Plan Provider:

a. Annual health maintenance examination with a primary care provider;
b. Annual fasting cholesterol profile and fasting blood sugar;
c. Routine laboratory tests (CBC, UA);
d. Liver test (ALT) and kidney function test (CR);
e. Heavy metal screening;
f. HIV, Hepatitis C screening (available upon request, or as indicated by current CDC guidelines);
g. Appropriate immunizations as recommended by your PCP;
h. One baseline ECG;
i. Cardiac testing (stress test or coronary artery calcium test);
j. Standard Kaiser Permanente cancer screening protocols for colon, prostate (PSA testing based on informed decision making), cervical, and breast cancer.

***Note:** If you are enrolled in a High Deductible Health Plan, Services that are non-preventive may be subject to your Deductible, Coinsurance, and/or Copayment.

The following Services may incur Deductible, Coinsurance, and/or Copayment amounts, depending on your plan type:

a. Behavioral health, chemical dependency, or sleep apnea screening (referral needed)
b. Eye exam (without a referral)
c. Hearing exam (available yearly, without a referral)
d. Any other test or screening based on recommendations from your PCP

If you have questions about the first responder benefit, please call **Member Services**.

This rider amends the EOC to provide additional coverage for first responders. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

FRST0AA (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage

   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations

   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions

   These exclusions apply to fertile as well as infertile individuals or couples.

   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.

f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

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Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

Important plan information

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EXHIBIT A-6
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-6: City and County of Denver Fire POS65 – Gold HMO EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the fire department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit An additional charge may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance (prostate cancer drugs only) All other office-administered drugs @ No Charge
• Travel immunizations *(Applies to Out-of-Pocket Maximum)*	No Charge
Virtual Care Services	
• Email o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$300 Copayment each surgery

Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $300

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	**You Pay**
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

Dental Services following Accidental Injury	**You Pay**
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Applies to Out-of-Pocket Maximum)	$30 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies to Out-of-Pocket Maximum)*	No Charge
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see “X-ray, Laboratory, and X-ray Special Procedures” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See “Outpatient Hospital and Surgical Services” for Out-of-Pocket Maximum information).*	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Does not apply to Out-of-Pocket Maximum)*	Applicable Copayment or Coinsurance applies

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services:* (*Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations:* (*Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $20 Copayment Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
o Over the counter (OTC) items *(Federally mandated over the counter items)* *(Applies to Out-of-Pocket Maximum)*	No Charge
o Tobacco cessation drugs *(Applies to Out-of-Pocket Maximum)*	No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Applied Behavioral Services	

• Applied Behavior Analysis (ABA) (*Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit

Prescription Drugs, Supplies, and Supplements	**You Pay**
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand Contraceptive drugs at No Charge Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Applies to Out-of-Pocket Maximum)* • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission

Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per inpatient admission

Transplant Services	**You Pay**
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll-free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:
   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."
   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."
   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies;
   ii. disposable syringes for the administration of insulin;
   iii. glucose test strips;
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure

is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;

d. Antiseptics;
e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing

covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate

arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the “Schedule of Benefits (Who Pays What).” Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado’s network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

M. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or

b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination,

and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if

circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the

date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

FIRST RESPONDER BENEFIT

Coverage

Your Group has purchased additional coverage for employees who qualify as first responders. The following screening tests and medical Services are covered at no charge* when performed by a Plan Provider:

a. Annual health maintenance examination with a primary care provider;
b. Annual fasting cholesterol profile and fasting blood sugar;
c. Routine laboratory tests (CBC, UA);
d. Liver test (ALT) and kidney function test (CR);
e. Heavy metal screening;
f. HIV, Hepatitis C screening (available upon request, or as indicated by current CDC guidelines);
g. Appropriate immunizations as recommended by your PCP;
h. One baseline ECG;
i. Cardiac testing (stress test or coronary artery calcium test);
j. Standard Kaiser Permanente cancer screening protocols for colon, prostate (PSA testing based on informed decision making), cervical, and breast cancer.

***Note:** If you are enrolled in a High Deductible Health Plan, Services that are non-preventive may be subject to your Deductible, Coinsurance, and/or Copayment.

The following Services may incur Deductible, Coinsurance, and/or Copayment amounts, depending on your plan type:

a. Behavioral health, chemical dependency, or sleep apnea screening (referral needed)
b. Eye exam (without a referral)
c. Hearing exam (available yearly, without a referral)
d. Any other test or screening based on recommendations from your PCP

If you have questions about the first responder benefit, please call **Member Services**.

This rider amends the EOC to provide additional coverage for first responders. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

FRST0AA (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage

   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations

   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions

   These exclusions apply to fertile as well as infertile individuals or couples.

   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.

f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

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Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

43450 **********AUTO**5-DIGIT 80121

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DENVER FIRE DEPARTMENT

Important plan information

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IR1JCMPL--COIN--CRCS0JDEDNADEN--DIAL0KDMEB0XDMES1IDPP--DUMYDMEMPH9XEPOT--EXAB--FAMF2FRST01GRP0NGYN0LHC02HCSS0IHH0LHOOP11HOS20WHRA--INFT0KLABBLMHBINAMHBO
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EXHIBIT A-7
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-7: City and County of Denver Fire (74) HMO RET EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

kp.org

KAISER PERMANENTE®

KAISER PERMANENTE®

Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the fire department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit An additional charge may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance (prostate cancer drugs only) All other office-administered drugs @ No Charge
• Travel immunizations *(Applies to Out-of-Pocket Maximum)*	No Charge
Virtual Care Services	
• Email o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$300 Copayment each surgery

Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $300

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	**You Pay**
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

Dental Services following Accidental Injury	**You Pay**
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Applies to Out-of-Pocket Maximum)	$30 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies to Out-of-Pocket Maximum)*	No Charge
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see “X-ray, Laboratory, and X-ray Special Procedures” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See “Outpatient Hospital and Surgical Services” for Out-of-Pocket Maximum information).*	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services:* (*Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations:* (*Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $20 Copayment Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
o Over the counter (OTC) items *(Federally mandated over the counter items)* *(Applies to Out-of-Pocket Maximum)*	No Charge
o Tobacco cessation drugs *(Applies to Out-of-Pocket Maximum)*	No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Applied Behavioral Services	

• Applied Behavior Analysis (ABA) (*Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit

Prescription Drugs, Supplies, and Supplements	**You Pay**
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand Contraceptive drugs at No Charge Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Applies to Out-of-Pocket Maximum)* • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission

Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per inpatient admission

Transplant Services	**You Pay**
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll-free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:
   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."
   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."
   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies;
   ii. disposable syringes for the administration of insulin;
   iii. glucose test strips;
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure

is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;

d. Antiseptics;
e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing

covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate

arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the “Schedule of Benefits (Who Pays What).” Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado’s network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

M. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or

b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination,

and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if

circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the

date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

FIRST RESPONDER BENEFIT

Coverage

Your Group has purchased additional coverage for employees who qualify as first responders. The following screening tests and medical Services are covered at no charge* when performed by a Plan Provider:

a. Annual health maintenance examination with a primary care provider;
b. Annual fasting cholesterol profile and fasting blood sugar;
c. Routine laboratory tests (CBC, UA);
d. Liver test (ALT) and kidney function test (CR);
e. Heavy metal screening;
f. HIV, Hepatitis C screening (available upon request, or as indicated by current CDC guidelines);
g. Appropriate immunizations as recommended by your PCP;
h. One baseline ECG;
i. Cardiac testing (stress test or coronary artery calcium test);
j. Standard Kaiser Permanente cancer screening protocols for colon, prostate (PSA testing based on informed decision making), cervical, and breast cancer.

***Note:** If you are enrolled in a High Deductible Health Plan, Services that are non-preventive may be subject to your Deductible, Coinsurance, and/or Copayment.

The following Services may incur Deductible, Coinsurance, and/or Copayment amounts, depending on your plan type:

a. Behavioral health, chemical dependency, or sleep apnea screening (referral needed)
b. Eye exam (without a referral)
c. Hearing exam (available yearly, without a referral)
d. Any other test or screening based on recommendations from your PCP

If you have questions about the first responder benefit, please call **Member Services**.

This rider amends the EOC to provide additional coverage for first responders. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

FRST0AA (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage

   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations

   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions

   These exclusions apply to fertile as well as infertile individuals or couples.

   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.

f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

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Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

Important plan information

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1JCMPL--COIN--CRCS0JDEDNADEN--DIAL0KDMEB0XDMES1IDPP--DUMYDMEMPH9XEPOT--EXAB--FAMF2FRST01GRP0NGYN0LHC0NHCSS0IHH0LHOOP11HOS20WHRA--INFT0KLABBLMHBINAMHBONA
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EXHIBIT A-8
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-8: City and County of Denver Fire (74) HMO EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the fire department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit An additional charge may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
• Travel immunizations *(Applies to Out-of-Pocket Maximum)*	No Charge
Virtual Care Services	
• Email	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$300 Copayment each surgery
Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $300

Hospital Inpatient Care	You Pay
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	You Pay
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	You Pay
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	You Pay
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

Dental Services following Accidental Injury	You Pay
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	You Pay
(Applies to Out-of-Pocket Maximum)	$30 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies to Out-of-Pocket Maximum)*	No Charge
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see “X-ray, Laboratory, and X-ray Special Procedures” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See “Outpatient Hospital and Surgical Services” for Out-of-Pocket Maximum information).*	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services:* (*Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations:* (*Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $20 Copayment Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
o Over the counter (OTC) items *(Federally mandated over the counter items)* *(Applies to Out-of-Pocket Maximum)*	No Charge
o Tobacco cessation drugs *(Applies to Out-of-Pocket Maximum)*	No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Applied Behavioral Services	

• Applied Behavior Analysis (ABA) (*Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit

Prescription Drugs, Supplies, and Supplements	**You Pay**
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand Contraceptive drugs at No Charge Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Applies to Out-of-Pocket Maximum)* • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission

Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per inpatient admission

Transplant Services	**You Pay**
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll-free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:
   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."
   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."
   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies;
   ii. disposable syringes for the administration of insulin;
   iii. glucose test strips;
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure

is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;

d. Antiseptics;
e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing

covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate

arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the “Schedule of Benefits (Who Pays What).” Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado’s network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

M. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or

b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination,

and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if

circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the

date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

FIRST RESPONDER BENEFIT

Coverage

Your Group has purchased additional coverage for employees who qualify as first responders. The following screening tests and medical Services are covered at no charge* when performed by a Plan Provider:

a. Annual health maintenance examination with a primary care provider;
b. Annual fasting cholesterol profile and fasting blood sugar;
c. Routine laboratory tests (CBC, UA);
d. Liver test (ALT) and kidney function test (CR);
e. Heavy metal screening;
f. HIV, Hepatitis C screening (available upon request, or as indicated by current CDC guidelines);
g. Appropriate immunizations as recommended by your PCP;
h. One baseline ECG;
i. Cardiac testing (stress test or coronary artery calcium test);
j. Standard Kaiser Permanente cancer screening protocols for colon, prostate (PSA testing based on informed decision making), cervical, and breast cancer.

***Note:** If you are enrolled in a High Deductible Health Plan, Services that are non-preventive may be subject to your Deductible, Coinsurance, and/or Copayment.

The following Services may incur Deductible, Coinsurance, and/or Copayment amounts, depending on your plan type:

a. Behavioral health, chemical dependency, or sleep apnea screening (referral needed)
b. Eye exam (without a referral)
c. Hearing exam (available yearly, without a referral)
d. Any other test or screening based on recommendations from your PCP

If you have questions about the first responder benefit, please call **Member Services**.

This rider amends the EOC to provide additional coverage for first responders. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

FRST0AA (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage

   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations

   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions

   These exclusions apply to fertile as well as infertile individuals or couples.

   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.

f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

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Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

Important plan information

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JCMPL--COIN--CRCS0JDEDNADEN--DIAL0KDMEB0XDMES1IDPP--DUMYDMEMPH9XEPOT--EXAB--FAMF2FRST01GRP0NGYN0LHC0NHCSS0IHH0LHOOP11HOS20WHRA--INFT0KLABBLMHBINAMHBONA
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EXHIBIT A-9
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-9: City and County of Denver Fire (74) HDHP 1500 EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. This EOC is for your Group's 2021 contract year.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "Out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

The health care coverage described in this EOC has been designed to be a High Deductible Health Plan (HDHP) compatible for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified High Deductible Health Plan.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the fire department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

A. For covered Services that **ARE** subject to the medical Deductible:

   1. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.

   2. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").

   3. Your applicable Copayment and Coinsurance may apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your medical Deductible applies to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

   1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your medical Deductible and/or OPM amounts.

For more information about your medical Deductible or OPM amounts, please call **Member Services** or go to **kp.org.**

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

AGGREGATE Medical Deductible *(Applies to Out-of-Pocket Maximum)*	$1,500/Individual per Accumulation Period $3,000/Family per Accumulation Period

An Aggregate Medical Deductible means:

• If you are the only person covered on your plan, the individual Medical Deductible amount applies. After the individual medical Deductible is met, the Member will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.

• If there are two or more family Members on your plan, the individual Medical Deductible amount does not apply. The entire family Medical Deductible must be met before Copayment or Coinsurance is applied for any individual family Member. No one in the family is considered to have met the Deductible until the entire family Deductible is met.

Out-of-Pocket Maximum

AGGREGATE OPM	$3,000/Individual per Accumulation Period $6,000/Family per Accumulation Period

An Aggregate OPM means:

• If you are the only person covered on your plan, the individual OPM amount applies. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.

• If there are two or more family Members on your plan, the individual OPM amount does not apply. The family OPM amount applies to the entire family as a whole. The entire family medical OPM amount must be met before any covered family Member will no longer pay Copayments or Coinsurance for covered Services. No one in the family is considered to have met the OPM until the entire family OPM is met.

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Consultations with clinical pharmacists *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Allergy evaluation and testing	
• Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance
• Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance
Allergy injections *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Gynecology care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Office-administered drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Travel immunizations *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, video visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Outpatient hospital Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Inpatient professional Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Alternative Medicine	**You Pay**
Chiropractic care	
• Evaluation and/or manipulation *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Bariatric Surgery	**You Pay**
(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dental Services following Accidental Injury	**You Pay**
(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	**You Pay**
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Durable Medical Equipment (DME) and Prosthetics and Orthotics	**You Pay**
Durable Medical Equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Not subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" medical Deductible and Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Urgent care outside Service Area *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See "Office Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Hearing aids for Members up to age 18 (*Subject to medical Deductible;* Applies to Out-of-Pocket Maximum)	20% Coinsurance
• Fitting and recheck visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Hearing aids for Members age 18 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services prescribed by a Plan Provider (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Hospice care for terminally ill patients (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance including partial hospitalization
Outpatient group therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: 20% Coinsurance Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: 20% Coinsurance
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Over the counter (OTC) items: *(Federally mandated over the counter items)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* o Tobacco cessation drugs *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge No Charge No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance; Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational and speech therapy visits	
• Habilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Pulmonary rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the medical Deductible and apply to the Out-of-Pocket Maximum except as otherwise listed in this "Prescription Drugs, Supplies, and Supplements" section.)*	$15 Generic/$40 Brand Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Pharmacy Deductible	Not Applicable
• Infertility drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to medical or pharmacy Deductible)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to medical or pharmacy Deducible)*	No Charge
Supply Limit	
• Day supply limit	60 days
• Mail-order supply limit	$15 Generic/$40 Brand Up to 60 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum*) • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam *(See "Office Services" or "Laboratory Services" for medical Deductible and Out-of-Pocket Maximum information.)*	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Intrauterine insemination (IUI) *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
In Vitro Fertilization (IVF) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance Limited to 100 days per Accumulation Period

Subustance Use Disorder Services	You Pay
Inpatient medical detoxification (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Inpatient professional Services for medical detoxification (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Outpatient individual therapy or intensive outpatient therapy (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance including partial hospitalization
Outpatient group therapy (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Residential rehabilitation (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance per inpatient admission

Transplant Services	You Pay
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care"for medical Deductible and Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
• Members age 19 and over *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
• Members age 19 and over *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Refraction test: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 20% Coinsurance Test: 20% Coinsurance
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Not subject to medical Deductible;* Does not apply to Out-of-Pocket Maximum)	Not Covered
• Members age 19 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Diagnostic X-ray Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
Therapeutic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*) • Diagnostic procedures include administered drugs. • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs")*	20% Coinsurance

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week	
CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health	
CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services	
CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services	
CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

4. Health Savings Account Eligibility

Enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be: (a) covered by another health coverage plan (for example, through your spouse's employer) that is not also an HSA-compatible health plan, with certain exceptions; (b) enrolled in Medicare; or (c) able to be claimed as a Dependent on another person's tax return. Consult your tax advisor for more information about your eligibility for an HSA.

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date.

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
      For existing Subscribers:
      i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
      ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

   b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
      For existing Subscribers:
      i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
      ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

   c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment
   You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling
   You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services**

if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.

11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.
    - Drugs (including Biologics and Biosimilars) and injectables;
    - Radioactive materials used for therapeutic purposes;
    - Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
    - Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and
4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.
   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.
2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

b. Prosthetic Devices Exclusions
   i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
   ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are subject to the Deductible and apply toward the Out-of-Pocket Maximum. EIS are not subject to any Copayments or Coinsurance.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. **Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)**
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would

have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area
There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."
   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. After your Deductible has been met, we also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational and speech therapy Coinsurance.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

In any Accumulation Period, you must pay full Charges for all drugs until you meet your Deductible. After you meet your Deductible, you pay the applicable Copayment or Coinsurance for these drugs for the rest of the Accumulation Period, subject to the annual Out-of-Pocket Maximum limits.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day

supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs

Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements

We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories

Prescribed supplies and accessories, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

i. home glucose monitoring supplies.
ii. disposable syringes for the administration of insulin.
iii. glucose test strips.
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage

   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion

   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services

   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation

   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services

   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion

   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage

   Transplants are covered on a limited basis as follows:

   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

b. Non-human and artificial organs and their implantation are excluded.

c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
a. Eyeglass lenses and frames.
b. Contact lenses.
c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment.

This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services**
    a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:

       i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
       ii. Is the subject of a current new drug or new device application on file with the FDA; or
       iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
       iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
       v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
       vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
       vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
       viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:

i. The Member's medical records; and
ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.

13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased supplemental coverage.

14. **Intermediate Care.** Care in an intermediate care facility.

15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.

17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.

20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.

21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

22. **Weight Management Facilities.** Services received in a weight management facility.

23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

    When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be

reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:
   i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

   ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
      2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

   B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
      2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
      3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
      4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
         - The **Plan** covering the **Custodial parent**;
         - The **Plan** covering the spouse of the **Custodial parent**;
         - The **Plan** covering the **non-custodial parent**; and then
         - The **Plan** covering the spouse of the **non-custodial parent**.

   C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

   iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

   iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

   v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

   vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the

Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any or from other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your

attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy

In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504).

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507).

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department**. To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

N. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Q. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan

Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)
   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:
   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance
You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if

you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

      If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

      We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

      We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

      If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

      If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

   b. Non-Urgent Pre-Service Appeal

      Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2)

your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.

Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim

Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your

medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision, if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not

provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal

claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

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

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:

- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126,

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Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

   c. Durable Medical Equipment Exclusions
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
      *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost or stolen equipment.
      viii. Repairs, adjustments, or replacements necessitated by misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements.
      x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions
   i. Dental prostheses, except for Medically Necessary prosthodontic treatment.
   ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
   iii. More than one prosthetic device for the same part of the body, except for replacements.
   iv. Spare devices or alternate use devices.
   v. Replacement of lost or stolen prosthetic devices.
   vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
   Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

FIRST RESPONDER BENEFIT

Coverage
Your Group has purchased additional coverage for employees who qualify as first responders. The following screening tests and medical Services are covered at no charge* when performed by a Plan Provider:
a. Annual health maintenance examination with a primary care provider;
b. Annual fasting cholesterol profile and fasting blood sugar;
c. Routine laboratory tests (CBC, UA);
d. Liver test (ALT) and kidney function test (CR);
e. Heavy metal screening;
f. HIV, Hepatitis C screening (available upon request, or as indicated by current CDC guidelines);
g. Appropriate immunizations as recommended by your PCP;
h. One baseline ECG;
i. Cardiac testing (stress test or coronary artery calcium test);
j. Standard Kaiser Permanente cancer screening protocols for colon, prostate (PSA testing based on informed decision making), cervical, and breast cancer.

***Note:** If you are enrolled in a High Deductible Health Plan, Services that are non-preventive may be subject to your Deductible, Coinsurance, and/or Copayment.

The following Services may incur Deductible, Coinsurance, and/or Copayment amounts, depending on your plan type:
a. Behavioral health, chemical dependency, or sleep apnea screening (referral needed)
b. Eye exam (without a referral)
c. Hearing exam (available yearly, without a referral)
d. Any other test or screening based on recommendations from your PCP

If you have questions about the first responder benefit, please call **Member Services**.

This rider amends the EOC to provide additional coverage for first responders. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

FRST0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage
   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain

specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

Non-Formulary Drug Exception Process:
You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

Prescribed supplies and accessories include, but may not be limited to:
a. Home glucose monitoring supplies.
b. Glucose test strips.
c. Acetone test tablets.
d. Nitrate urine test strips for pediatric patients.
e. Disposable syringes for the administration of insulin.

Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:
a. Plan Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:
a. Drugs for which a prescription is required by law.
b. Insulin.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.

g. Drugs to enhance athletic performance.
h. Drugs available over the counter and by prescription for the same strength.
i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
j. Drugs for the treatment of weight control.
k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
m. Drugs administered during a medical office visit.
n. Medical Foods and Medical Devices.
o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

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Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

Important plan information

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EXHIBIT A-10
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-10: City and County of Denver Fire (74) POS 300 EOC.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2021 contract year.

kp.org

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Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (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, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2021

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the fire department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, a lawful partner in a civil union in accordance with the Colorado Civil Union Act or spousal equivalent.

11) "Spousal equivalent" shall mean an adult of the same gender with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency or may register as a committed partnership with the clerk's office.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the “Schedule of Benefits (Who Pays What)”; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

KAISER PERMANENTE®

AMENDMENT TO
EVIDENCE OF COVERAGE

POINT-OF-SERVICE (POS) PLANS

Your "POS Plan" coverage gives you access to two different health care options each time you seek care. You can receive Services through Kaiser Foundation Health Plan (Health Plan) or through your separate coverage provided by the Kaiser Permanente Insurance Company (KPIC).

For assistance with questions regarding your coverage and benefits, please call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

This Evidence of Coverage (EOC) describes the Services covered by Health Plan that you receive from Plan Providers at Plan Facilities. The KPIC *Certificate of Insurance,* provided to you separately by KPIC, describes the Services covered by KPIC that you receive from participating providers and/or non-participating providers. KPIC coverage is not described in this EOC. To request a printed copy of your KPIC *Certificate of Insurance*, please call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

The benefits, Deductibles, Copayments, and/or Coinsurance for Health Plan and KPIC are not the same. Some Services may be covered by one health care option, but not the other. A covered Service will be covered by one of the options, but never by both. Neither Health Plan nor KPIC is responsible for a Member's decision to access care under this EOC or the KPIC *Certificate of Insurance*.

Amounts paid toward the Deductibles and Out-of-Pocket Maximum for Services received from Health Plan cannot be used to satisfy the Deductible and Out-of-Pocket Maximum for Services received in KPIC's participating provider or non-participating provider tier or benefit level. However, in some cases, amounts paid toward the Deductibles and Out-of-Pocket Maximum for Services received from KPIC's participating provider or non-participating provider tier or benefit level may be used to satisfy the Deductible and Out-of-Pocket Maximum for Services received from Health Plan. Please refer to your KPIC *Certificate of Insurance* for a complete explanation.

Certain Services covered under your "POS Plan" have combined benefit maximums, with respect to the number of visits or number of days, across the Health Plan and KPIC options. See your KPIC *Certificate of Insurance* for more information about which Services have combined benefit maximums.

Please note prescriptions obtained from KPIC providers may be filled at Plan Pharmacies at the applicable Health Plan charge for medications on the Health Plan formulary; and routine lab and diagnostic X-ray orders obtained from KPIC providers may be brought to Health Plan Facilities and will be charged at the applicable Health Plan benefit level.

When you access your Health Plan benefits covered under this EOC, you are selecting Kaiser Permanente's medical care program to provide your health care.

The following sections of your EOC are amended, as follows:

I. Section III. BENEFITS/COVERAGE (WHAT IS COVERED), is amended by deleting, in its entirety, the Subsection titled "Out-of-Area Benefit." Any references to "Out-of-Area Benefit" in the "Schedule of Benefits (Who Pays What)", or anywhere else in this EOC, are also deleted in their entirety.

II. Section IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED), Subsection "A. Exclusions" is amended to read as follows:

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What Is Covered)" section. If a Service is not covered under this EOC, check your KPIC *Certificate of Insurance* to determine if it is covered by KPIC.

KAISER PERMANENTE®

AMENDMENT TO
EVIDENCE OF COVERAGE

POINT-OF-SERVICE (POS) PLANS

III. Section IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED), Subsection "C. Reductions, 1. Coordination of Benefits (COB)" is amended by *adding* **the following paragraph to this subsection:**

Note: The benefits administered by Health Plan as described in this EOC and the benefits administered by KPIC as described in your KPIC *Certificate of Insurance* are considered one plan for the purposes of coordination of benefits. Since a Service cannot be covered by both coverage options at the same time, there is no coordination of benefits between the two coverage options.

IV. Section VII. GENERAL POLICY PROVISIONS is amended by *adding* **the following provision:**

POS Coverage

Health Plan is not responsible for the obligations of KPIC nor for its decisions regarding KPIC claims and benefits. KPIC is not responsible for the obligations of Health Plan nor for our decisions regarding claims and benefits. Health Plan is not responsible for your decision to access Services from providers not contracting with us, the qualifications of these providers, or the Services they furnish. Furthermore, we are not liable for any act or omission of (1) such provider or the agents, officers, or employers of any of them, or (2) any other person or organization with which such providers have made or hereafter make arrangements for performance of Services.

V. The introductory paragraph of Section VIII. TERMINATION/NONRENEWAL/CONTINUATION is amended by adding the following paragraph:

If for any reason, you lose your KPIC coverage administered by KPIC, your Health Plan coverage described in this EOC will terminate on the same date. Check with your Group to discuss alternative health plan options.

VI. Section XI. DEFINITIONS is amended by *adding* **the following definition:**

Kaiser Permanente Insurance Company (KPIC): a California-domiciled insurance company licensed to conduct the business of insurance in Colorado and which underwrites the coverage for the Services that you receive from participating and/or non-participating providers of Kaiser Permanente's Point-of-Service (POS) plans. KPIC is a wholly owned subsidiary of Kaiser Foundation Health Plan, Inc.

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $3,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit An additional charge may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
• Travel immunizations *(Applies to Out-of-Pocket Maximum)*	No Charge
Virtual Care Services	
• Email	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider online via kp.org	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$300 Copayment each surgery
Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $300

Hospital Inpatient Care	You Pay
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	You Pay
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	You Pay
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	You Pay
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

Dental Services following Accidental Injury	You Pay
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	You Pay
(Applies to Out-of-Pocket Maximum)	$30 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
• Peak flow meters *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies to Out-of-Pocket Maximum)*	No Charge
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits. If you receive Observation Services, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.	
Plan and Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see “X-ray, Laboratory, and X-ray Special Procedures” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning and Sterilization Services	**You Pay**
Family planning counseling *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See “Outpatient Hospital and Surgical Services” for Out-of-Pocket Maximum information).*	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.

Health Education Services	**You Pay**
Training in self-care and preventive care *(See “Office Services” for Out-of-Pocket Maximum information.)*	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Does not apply to Out-of-Pocket Maximum)* *Other Services:* (*Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations:* (*Does not apply to Out-of-Pocket Maximum)*	Visit limit: Not applicable Visit: Not Covered Other Services received during an office visit: Not Covered Preventive immunizations: Not Covered
Diagnostic X-ray Services *(Does not apply to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Not applicable Not Covered
Outpatient physical, occupational, and speech therapy visits *(Does not apply to Out-of-Pocket Maximum)*	Therapy visit limit: Not applicable Visit: Not Covered
Outpatient prescription drugs	Prescription drug fills: Not applicable
• Copayment/Coinsurance (except as listed below) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Prescribed diabetic supplies *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Preventive drugs	Not Covered
o Contraceptive drugs *(Does not apply to Out-of-Pocket Maximum)*	
o Over the counter (OTC) items *(Federally mandated over the counter items)* *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
o Tobacco cessation drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$20 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) (*Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand Contraceptive drugs at No Charge Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply
o Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs *(Not subject to pharmacy Deductible)*	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Applies to Out-of-Pocket Maximum)* • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a provider online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per admission

Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$20 Copayment each visit $20 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$750 Copayment per inpatient admission

Transplant Services	**You Pay**
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $20 Copayment each visit Test: $20 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the "Eligibility" section in the EOC.

Additional Provisions

Please see "Additional Provisions" for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services

CALL	**303-338-3800** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Appeals Program

CALL	**303-344-7933** or toll-free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling

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

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call **Appointments and Medical Advice** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call **Appointments and Medical Advice** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, he or she will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, he or she will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at an Out-of-Plan Facility inside our Service Area may not be covered. If you receive care for minor medical problems at Out-of-Plan Facilities inside our Service Area, you may be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside our Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, Coinsurance, limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:
   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**

   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

   Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside our Service Area.

Note: If you receive urgent care outside the Service Area, you may be responsible for any amounts over eligible Charges, in addition to any Deductible, Copayment, or Coinsurance. The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

L. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services, home infusion therapy, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered and provided by a Plan Provider or self-administered. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

   Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

N. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:

   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

O. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover individual visits, group visits, and intensive outpatient therapy.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Services which are custodial or residential in nature.

P. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

Q. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."
   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."
   c. Multidisciplinary Rehabilitation Services
      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

   Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs
Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies;
   ii. disposable syringes for the administration of insulin;
   iii. glucose test strips;
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

   For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

V. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

W. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Provider.

   We cover substance use disorder Services, whether they are voluntary or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Provider identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered

transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

b. Plan Providers must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure

is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery.

Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

b. Inpatient
During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;

d. Antiseptics;
e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of his or her license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
      iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
      v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
      vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
      vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
      viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

   b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
      i. The Member's medical records; and
      ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
      iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
      iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
      v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
      vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

   c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

12. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Utilization Management Program Criteria.
13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
14. **Intermediate Care.** Care in an intermediate care facility.
15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.
17. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
18. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
20. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
21. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
22. **Weight Management Facilities.** Services received in a weight management facility.
23. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: 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 not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing

covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits fault. Proceeds of such judgment, award or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against another party, entity or insurer, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party or entity and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of another party, entity or insurer. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Traditional or Gestational Surrogacy
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate

arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the “Schedule of Benefits (Who Pays What).” Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado’s network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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 non-covered Services or Services you obtain from Out-of-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 Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

M. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Plan Facility or on our website, kp.org**.**

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or

b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination,

and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if

circumstances beyond our control delay our decision, if we send you notice before the initial 15 days end and explain why we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent to your provider.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the

date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review that may be available to you.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan 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 Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or

4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as required to Stabilize the patient to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290, 82063, 82070, 82082.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

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 (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DOMP0AA (01-18)

GREX0AA

Grandchild Exclusion

In accordance with your Group contract, a grandchild (including an adopted or foster grandchild) of you or your Spouse is not eligible to enroll as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild.

GREX0AA_21 (01-21)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Dependents include your:
1. Spouses; and
2. Other eligible Dependents.

Their coverage may continue based on the Group's personnel policy.

SRDC0AE (01-12)

WOR0AA

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

The following paragraph of your EOC is amended, as follows:

I. Eligibility

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and

b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

c. The Subscriber must live, reside, or work in our Service Area. Our Service Area is described in the "Definitions" section.

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

WOR0AA (01-20)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-21)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of

use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.

ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.

iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.

v. Comfort, convenience, or luxury equipment or features.

vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages.
*Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.

vii. Replacement of lost or stolen equipment.

viii. Repairs, adjustments, or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.

x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices

a. Coverage

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:

i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.

ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.

iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions

i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.

iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.

v. Replacement of lost or stolen prosthetic devices.

vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices

a. Coverage

Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions

i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.

iv. More than one orthotic device for the same part of the body, except for covered replacements.

v. Spare devices or alternate use devices.

vi. Replacement of lost or stolen orthotic devices.

vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations
   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions
   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen, sperm, or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
   f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-21)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.

3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:

a. Plan Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:

a. Drugs for which a prescription is required by law.
b. Insulin.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-21)

NOTES

NOTES

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

Important plan information

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CMPL--COIN--CRCS0JDEDNADENNADIAL0KDMEB0XDMES1IDPP--DUMYDMEMPH9XEPOT--EXAB--FAMF2FRST--GRP0NGYN0LHC0NHCSS0IHH0LHOOP11HOS20WHRA--INFT0KLAB0KMHBINAMHBONAM
HIP38OPMINOVC23HOXYG0UPNMT1JPP--REHB11REOP8ZSGOP65SNF0MSNKR--STU--TABS4CTRAN0KTRGNCCTRVL--VADD--WLCH1CXPRO0MXRAY0KCDOP0LMHOP0MHEAR0LSPVC0LOVC0JRX02R
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EXHIBIT A-11
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-11: City and County of Denver Fire (74) PPO 300 Certificate of Insurance.

KAISER PERMANENTE

Kaiser Permanente Insurance Company

Colorado

Preferred Provider Organization

KAISER PERMANENTE

Kaiser Permanente Insurance Company

Mar.17,2021

Re: Policyholder: DENVER FIRE DEPARTMENT
Group Policy Number: 74-084

Dear Insured Employee:

Thank you for choosing Kaiser Permanente Insurance Company (KPIC).

Enclosed are your Certificate of Insurance and Schedule of Benefits for the current plan year. They supersede and replace any Certificate of Insurance or Schedule of Benefits that KPIC may have previously issued to you or your employer. The Certificate is evidence of your coverage under the KPIC Group Insurance Policy issued to your employer. Please read your Certificate carefully and keep it in a safe place.

If you have questions regarding your eligibility or plan benefits, please contact your employer.

Again, thank you for being a part of the Kaiser Permanente Health Care Program.

Sincerely,

KAISER PERMANENTE INSURANCE COMPANY

CO SUB Ltr.3

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

SCHEDULE OF BENEFITS (Who Pays What)

Group Name: DENVER FIRE DEPARTMENT **Group Number: 74-084**
Original Effective Date of Insurance: On File

COVERED PERSONS:	Employees and Dependents, if elected	
Dependent Child Age Limit:	Age 26, covered through the end of the month in which the age limit is reached	
LIFETIME MAXIMUM BENEFIT WHILE INSURED:	Not applicable	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Accumulation Period:	Calendar Year January 1- December 31	
Accumulation Period DEDUCTIBLES		
Self Only (Family of One Covered Person):	$300	$400
Individual (any one Covered Person in a family of two or more Covered Persons):	$300	$400
Family (for an entire family of two or more Covered Persons):	$900	$1,200
Accumulation Period OUT-OF-POCKET MAXIMUMS		
Self Only (Family of One Covered Person):	$3,000	$6,000
Individual (any one Covered Person in a family of two or more Covered Persons):	$3,000	$6,000
Family (for an entire family of two or more Covered Persons):	$9,000	$18,000

NOTE:

1. *Covered Charges applied to satisfy Deductible and Cost Shares on Covered Services applied to satisfy Out-of-Pocket Maximums at the Participating Provider Tier will not be applied towards satisfaction of Deductibles and Out-of-Pocket Maximums at the Non-Participating Provider Tier. Likewise, Covered Charges applied to satisfy Deductibles and Cost Shares on Covered Services applied to satisfy Out-of-Pocket Maximums at the Non-Participating Provider Tier will not be applied towards satisfaction of Deductibles and Out-of-Pocket Maximums at the Participating Provider Tier.*
2. *Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured or any dollar Benefit Maximum. Unless otherwise prohibited by applicable law, day or visit limits may be imposed upon Essential and non-Essential Health Benefits.*
3. *Deductible, Coinsurance and Co-payments do not apply to Preventive Benefits required under the Patient Protection Affordable Care Act (PPACA) at the Participating Provider Tier. Preventive Benefits required under the Patient Protection and Affordable Care Act (PPACA) that are received at the Non-Participating Provider Tier, however, are subject to Cost Sharing.*
4. *Covered non-preventive services provided during a preventive exam may be subject to the Deductible and applicable Copayments and Coinsurance.*

IMPORTANT: *Read the section in Your Certificate of Insurance regarding Pre-certification carefully.*

No portion of a balance billing that exceeds the level of the Maximum Allowable Charge will count towards any Deductible, Coinsurance, or Out-of-Pocket Maximum, which is applicable under the Group Policy.

For a complete understanding of the benefits, exclusions, and limitations applicable to your coverage, this ***SCHEDULE OF BENEFITS (Who Pays What)*** *must be read in conjunction with the Certificate of Insurance.*

COVERED SERVICES	**YOUR COST SHARE (What You Pay)**	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Outpatient Services		
Office Visits:	Lab, X-ray and all other services are subject to Coinsurance after Deductible	Lab, X-ray services and all other services are subject to Coinsurance after Deductible
Primary Care:		
Office visit	$20 Copayment per visit (Deductible does not apply)	40%
Virtual Care Services*:		
Video visit	No Charge (Deductible does not apply)	40%
Email/Online visit	No Charge (Deductible does not apply)	40%
Telephone visit	No Charge (Deductible does not apply)	40%

*Includes Virtual Care Services obtained from Behavioral Health/Mental Health and Substance Use Disorder Providers

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Specialty Care:		
Office visit	$20 Copayment per visit (Deductible does not apply)	40%
Virtual Care Services:		
Video visit	No Charge (Deductible does not apply)	40%
Email/Online visit	No Charge (Deductible does not apply)	40%
Telephone visit	No Charge (Deductible does not apply)	40%
Allergy Diagnosis and Testing:		
By a Primary Care Provider	$20 Copayment per visit (Deductible does not apply)	40%
By a Specialty Care Provider	$20 Copayment per visit (Deductible does not apply)	40%
Allergy Treatment and Materials:		
Injection Visit:	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Serum:	20%	40%
Prenatal and postnatal Care:	20%	40%
Outpatient Surgery:	20%	40%
Chiropractic Care Spinal Manipulation Services:	$20 Copayment per visit (Deductible does not apply)	Not Covered
	Limited to a combined Benefit Maximum of 20 visits per Accumulation Period.	
Medically Necessary Bariatric Surgery:	Not Covered	Not Covered
Inpatient Hospital Care	20%	40%
Medically Necessary Bariatric Surgery:	Not Covered	Not Covered

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Ambulance	20%	Covered at the Participating Provider Benefit level regardless of the participating status of the provider.
Autism Spectrum Disorders		
Applied Behavior Analysis:	$20 Copayment per visit (Deductible does not apply)	40%
Physical, Occupational and Speech Therapy:	$20 Copayment per visit (Deductible does not apply)	40%
Behavioral Health/Mental Health Services		
Inpatient:	20%	40%
Outpatient:		
Individual Visits	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Group Therapy	$10 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Partial Hospitalization	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Dental		
Hospital services for dental procedures:	20%	40%
Dialysis Care	20%	40%
Drugs, Supplies and Supplements		
Drugs administered in the Office Setting/Outpatient Hospital Setting:	20%	40%
Medical Foods:	$3 Copayment per product per day (Deductible does not apply)	$3 Copayment per product per day (Deductible does not apply)

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Outpatient Prescription Drugs:	Prescription Drug deductible: None Preferred Generic: $20 Copayment per prescription, Deductible does not apply Preferred Brand: $30 Copayment per prescription, Deductible does not apply Specialty Drugs: 20%, limited to $250 cost share per prescription, Deductible does not apply Oral Anti-cancer Drugs: 20%, Deductible does not apply Diabetic Supplies: $20 Copayment, Deductible does not apply Day Supply: 30	Prescription Drug deductible: None Generic: Not covered Brand: Not covered Oral Anti-cancer Drugs: 40%, Deductible does not apply Diabetic Supplies: 20%, Deductible does not apply Day Supply: 30
Insulin	Applicable Cost Share Corresponding to the appropriate Formulary Tier Not to Exceed $100 Cost Share per prescription for a 30-day supply	Applicable Cost Share Corresponding to the appropriate Formulary Tier Not to Exceed $100 Cost Share per prescription for a 30-day Supply
Mail Order	Same Coinsurance as retail, or if applicable, Co-payments payable for Mail Order service is 2 times the corresponding single Co-payment per prescription amount shown above, limited to a 90-day supply.	Not Available
Durable Medical Equipment/External Prosthetics and Orthotics		
Durable Medical Equipment and Orthotics:	20%	40%
Oxygen:	20%	40%
External Prosthetic Devices to replace an arm or a leg:	20% (Deductible does not apply)	20%
Dressings, casts and splints	20%	40%
Other covered External Prosthetics	20%	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Early Childhood Intervention Services	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)
	Limited to a combined Benefit Maximum of 45 Therapeutic Visits, per Accumulation Period, for Dependents from birth up to age 3	
Emergency Services	20%	Covered at the Participating Provider Benefit level regardless of the participating status of the provider.
Hearing Services		
Routine Exam by Audiologist for Adults (age 18 and over):	$20 Copayment per visit (Deductible does not apply)	40%
Routine Exam by Audiologist for Minors (under age 18):	$20 Copayment per visit (Deductible does not apply)	40%
Hearing Aids for Adults (age 18 and over):	Not covered	Not covered
Hearing Aids Fitting and Recheck Visit for Adults (age 18 and over):	Not covered	Not covered
Hearing Aids for Minors (under the age of 18):	20%	40%
Hearing Aid Fitting and Recheck Visit for Minors (under the age of 18):	20%	40%
Home Health Care	20%	40%
	Limited to a combined Benefit Maximum of 60 Visits per Accumulation Period	
Hospice Care	No Charge (Deductible does not apply)	40%
Infertility Services		
Diagnosis and Treatment of Underlying Conditions	20%	40%
Artificial Insemination	20%	40%
	Limited to a combined benefit Maximum of 3 cycle of Intrauterine Insemination (IUI) per lifetime.	

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Preventive Care Services		
Exams:	No Charge (Deductible does not apply)	40%
Screenings:	No Charge (Deductible does not apply)	40%
Health Promotion:	No Charge (Deductible does not apply)	40%
Listed Over-the-Counter Drugs and Over-the-Counter Contraceptives; and all Tobacco Cessation Drugs	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)
All other Contraceptives	No Charge (Deductible does not apply)	40%
Disease prevention:	No Charge (Deductible does not apply)	40%
Other Preventive Care:		
Family Planning:	20%	40%
Preventive Care Durable Medical Equipment		
Peak Flow Meters	20% (Deductible does not apply)	40%
Glucometers and Supplies	20% (Deductible does not apply)	20% (Deductible does not apply)
All Other Preventive Care	No Charge (Deductible does not apply)	40%
Rehabilitation and Habilitation Services		
Inpatient Multidisciplinary Rehabilitation or Habilitation Program, including one in Comprehensive Rehabilitation Facility:	20%	40%
	Limited to a combined Benefit Maximum of 60 days per condition per Accumulation Period	
Outpatient		
Pulmonary Therapy:	$20 Copayment per visit (Deductible does not apply)	40%
Cardiac Rehabilitation:	$20 Copayment per visit	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
	(Deductible does not apply)	
Rehabilitative Physical Therapy, Occupational Therapy and Speech Therapy:	$20 Copayment per visit (Deductible does not apply)	40%
	Limited to a combined Benefit Maximum of 20 visits per therapy, per Accumulation Period Visit Limits are not applicable to treat a Covered Person's congenital defects and birth abnormalities for physical, occupational and speech therapies from birth to age 6.	
Habilitative Physical Therapy, Occupational Therapy and Speech Therapy:	$20 Copayment per visit (Deductible does not apply)	40%
	Limited to a combined Benefit Maximum of 20 visits per therapy per Accumulation Period Visit Limits are not applicable to treat a Covered Person's congenital defects and birth abnormalities for physical, occupational and speech therapies from birth to age 6.	
Skilled Nursing Facility Services	20%	40%
	Limited to a combined Benefit Maximum of 100 days per Accumulation Period.	
Substance Use Disorder Services		
Inpatient:	20%	40%
Outpatient:		
Individual Visits	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Group Therapy	$10 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Partial Hospitalization	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Transgender Surgery	Covered the same as any other Inpatient or Outpatient Surgery	Covered in the Participating Provider Tier only.

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Transplants	20%	40%
Urgent Care Facility Services	20%	40%
Vision Care		
Routine Eye Exam by Optometrist for:		
Minors	$20 Copayment per visit (Deductible does not apply)	40%
Adults	$20 Copayment per visit (Deductible does not apply)	40%
Routine Eye Exam by Specialist for:		
Minors	$20 Copayment per visit (Deductible does not apply)	40%
Adults	$20 Copayment per visit (Deductible does not apply)	40%
Refractive Eye Test by Optometrist for:		
Minors	20%	40%
Adults	20%	40%
Refractive Eye Test by Specialist for:		
Minors	20%	40%
Adults	20%	40%
X-Ray, Lab and Special Procedures		
Outpatient CT/MRI/PET and Nuclear Medicine Scans:	20%	40%
All other X-ray, Lab and Special procedures:	20%	40%
All Other Covered Services*	20%	40%

*Other Covered Services refer to Covered Services listed under the **BENEFITS/COVERAGE (What is covered)** Section of the Certificate of Insurance that are not detailed under the **SCHEDULE OF BENEFITS (Who Pays What)**. Unless otherwise stated, Your Cost Share for other Covered Services is as shown above. Unless specifically stated in this **SCHEDULE OF BENEFITS (Who Pays What)**, Other Covered Services are subject to applicable Coinsurance after Deductibles.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: KPIC Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

END-OF-LIFE DRUG EXCLUSION RIDER

The **END-OF-LIFE DRUG EXCLUSION RIDER** applies to Groups that have elected not to cover prescriptions for the lethal drug and accompanying drugs written according to Colorado End of Life Options Act. This Rider is issued and made part of the Group Policy/Certificate to which it is attached.

By attachment of this Rider, the provisions of the Certificate of Insurance (COI) particularly the Exclusions for Outpatient Prescription Drug Benefits under the Drugs, Supplies and Supplements subsection of the **BENEFITS/COVERAGE (What is covered)** section, is amended, by adding the following exclusion:

"Prescriptions for the lethal drug and accompanying drugs for terminal illness."

This Rider does not change, waive or extend any part of the Group Policy/Certificate other than as set forth above. This Rider is subject to all the provisions of the Group Policy/Certificate that are not in conflict with this Rider. In the event this Rider creates a duplication of benefits, duplicate benefits will not be paid, but the higher of the applicable benefits will apply. This Rider is effective on the same date as the Group Policy to which it is attached, unless a different date is shown above. This Rider terminates on the same date as the Group Policy to which it is attached.

Charles P. Bevilacqua
President

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Colorado

Preferred Provider Organization Large Group (*Non-grandfathered Coverage)*

Certificate of Insurance

TITLE PAGE (Cover Page)

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverage funded through a Group Insurance Policy issued to Your group by Kaiser Permanente Insurance Company (hereafter referred to as "KPIC"). It becomes Your Certificate of Insurance when You have met certain eligibility requirements.

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit Payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. The Group Policy may be amended at any time without Your consent. If, any such amendment to the Policy is deemed to be a material modification, a 60-day prior notice will be sent to You before the effective date of the change. Any such amendment will not affect a claim initiated before the amendment takes effect. The Group Policy is available for inspection at the Policyholder's office.

This Certificate supersedes and replaces any and all certificates that may have been issued to You previously for the coverage described herein.

A Covered Person is entitled to choose between two levels of coverage with this Preferred Provider Organization (PPO) plan. The level of coverage depends on the provider that renders the treatment or service. Your coverage includes specified medical and Hospital services rendered by providers contracted by KPIC (hereafter referred to as "Participating Providers"). These services obtained from the Participating Providers are covered under the Participating Provider Tier. Your coverage also includes services rendered by any other providers that have not been contracted by KPIC (hereafter referred to as Non-Participating Providers). Services obtained from Non-Participating Providers are covered under the Non-Participating Provider Tier. Some services are covered under both the Participating Provider and Non-Participating Provider Tiers and others are covered only under the Participating Provider Tier. The provider You select can affect the dollar amount You must pay.

KPIC is not responsible for any Covered Person's decision to receive treatment, services or supplies under either level of coverage.

Payments will be made under either the Participating Provider Tier or the Non-Participating Provider Tier of the PPO plan but not under both.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "we", "us", or "our". The Insured Employee named in the attached **SCHEDULE OF BENEFITS (Who Pays What)** section will be referred to as: "You", or "Your".

This Certificate is important to You, so please read it carefully and keep it in a safe place.

Please refer to the LIMITATIONS and EXCLUSIONS (What is Not Covered) section of this Certificate for a description of this health insurance plan's general limitations and exclusions. Likewise, the SCHEDULE OF BENEFITS (Who Pays What) section contains specific limitations for specific benefits.

Note: If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in the TERMINATION/NON-RENEWAL/CONTINUATION section.

Colorado state law requires that an Access Plan be available that describes Kaiser Permanente Insurance Company (KPIC) Colorado's network of provider Services. To obtain a copy, please call **Customer Service** at 1-855- 364-3184 or visit https://choiceproducts-colorado.kaiserpermanente.org/ppo-plan/member-information/.

CONTACT US

This Certificate describes the KPIC Preferred Provider Organization (PPO) Plan.

This Certificate uses many terms that have very specific definitions for the purpose of the Group Policy. These terms are defined in the **DEFINITIONS** section and are capitalized so that You can easily recognize them. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Group Policy are defined in those sections. Please read all definitions carefully.

This Certificate includes a **SCHEDULE OF BENEFITS (Who Pays What)** section that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Certificate of Insurance for a more complete description of Your coverage and the exclusions and limitations under this medical insurance plan.

This Certificate forms the remainder of the Group Policy. The provisions set forth herein, are incorporated into, and made part of, the Group Policy.

Who Can Answer Your Questions?

For assistance with questions regarding Your coverage, such as Your benefits, Your current eligibility status, or name and address changes, please have Your ID card available when You call:

1-855-364-3184 (Toll-free)
711 (TTY)

Or You may write to the Administrator:

Kaiser Foundation Health Plan of Colorado
PO Box 370897
Denver, CO 80237-0897

PPO - If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll-free number listed in the Participating Provider directory.

For Pre-certification of Covered Services or Utilization Review of medical benefits other than Outpatient Prescription Drugs, please call the number listed on Your ID card or call 1-888-525-1553.

For Prior Authorization of certain Outpatient Prescription Drugs, please call the number listed on Your ID card or call 1-800-788-2949 (Pharmacy Help Desk).

TABLE OF CONTENTS

The sections of the Certificate appear in the order set forth below.
SCHEDULE OF BENEFITS (Who Pays What) section*

***Issued with this Certificate. Please consult Your Group Administrator if You did not receive a SCHEDULE OF BENEFITS (Who Pays What) section.**

ELIGIBILITY

Eligible for Insurance
You must be an Eligible Employee or Dependent of an Eligible Employee to become insured under the Group Policy.

Eligible Employee
Eligible Employee means a person who, at the time of original enrollment:
a. Is working for a Policyholder as a full-time employee as described below or is entitled to coverage under an employment contract;
b. By virtue of such employment or contract enrolls under the Group Policy and;
c. Reached an eligibility date.

Eligible Employee includes sole proprietors, partners of a partnership, or independent contractor if they are included as employees under a health benefit plan of the Policyholder, engaged on a full-time basis in the employer's business or are entitled to coverage under an employment contract.

The term **"Eligible Employee"** does not include employees who work on a temporary, seasonal or substitute basis.

For an Eligible Employee to become a Covered Person, the Eligible Employee must:
1. Complete a KPIC or KPIC-approved enrollment form;
2. Provide any information needed to determine the Eligible Employee's eligibility, if requested by Us;
3. Agree to pay any portion of the required premium, if applicable, and
4. Must live or work within a geographical area specified by KPIC and the Policyholder.

Full-Time Work
The terms "**full-time**", "**working full-time**", "**work on a full-time basis**", and all other references to full- time work mean that the Eligible Employee is actively engaged in the business of a Policyholder for at least 20 hours per week.

Permanent Employee
A "**permanent employee**" is a person scheduled to work full-time and is not a seasonal, temporary, or substitute employee.

Contributions
You must pay part of the cost of the insurance, unless the Policyholder's Application for coverage specifies that the Policyholder will pay the full cost of the Covered Person's' coverage. In no event will the Policyholder contribute less than one-half of the cost of the employee's insurance.

Eligibility Date
Your Eligibility Date is the date Your employer becomes a Policyholder if You are an Eligible Employee on that date, or the Policyholder's Application for coverage indicates that the eligibility waiting period does not apply to initial employees. Otherwise, Your eligibility date is the first day of the calendar month coinciding with or next following the date You complete the eligibility waiting period which shall not exceed 90 days elected by the Policyholder.

Effective Date of Your Insurance
Your effective date of insurance is described in the subsection Enrollment Rules for Eligible Employee or Dependent provision set forth below under this section.

If an Eligible Employee is not in Active Service on the date coverage would otherwise become effective, the coverage for that individual will not be effective until the date of return to Active Service. Any delay in an Eligible Employee's Effective Date will not be due to a health status-related factor as defined under the Health Insurance and Portability and Accountability Act of 1996, or as later amended.

ELIGIBILITY

Active Service means that a Covered Person: (1) is present at work with the intent and ability to work the scheduled hours; and (2) is performing in the customary manner all of the regular duties of his or her employment.

Eligibility of an Eligible Employee's Dependent
See the Definition section for the definition of a Dependent. (Please check with Your employer if Dependent coverage is available under Your plan)

Age Limits for Dependent Children
The age limit for Dependent children is under **26** years. If your employer elected to make coverage available under Your Plan beyond this age limit for Dependent children who are full-time students, then a Dependent child beyond this age limit who is a full-time student may be covered. The Dependent child must be of an age within the Student Age Limit as shown in your Schedule of Coverage. A **"full-time student"** is a Dependent child who is enrolled at a high school, college, university, technical school, trade school, or vocational school on a full-time basis. A **"full time student"** may also include, those who are on medical leave of absence from the school or those who have any other change in enrollment in school) due to a Medically Necessary condition as certified by the attending Physician. Such student coverage shall commence on the earlier of: the first day of the medical leave of absence; or on the date certified by the Physician. Coverage for students on medical leave of absence is subject to a maximum of 12 months and shall not continue beyond the effective date of the termination of the Group Policy.

Proof of status as a **"full time student"** must be furnished to KPIC at time of enrollment or within 31 days after attaining such status and subsequently as may be required by KPIC.

Exceptions
The Dependent Age Limit for Dependent Children does not apply to a Dependent child who is unmarried and continues to be both: 1) physically or mentally disabled and 2) dependent upon You for support and maintenance. Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the physically or mentally disabling sickness, injury or condition; or b) the date the child no longer depends on You for support and maintenance.

The above exception also applies to a **"full time student"** who is on medical leave of absence as described above, if, as a result of the nature of the sickness, injury, or condition, would render the dependent child physically or mentally disabled and dependent upon You for support and maintenance.

Proof of such incapacity and dependency must be submitted to KPIC within 60 days of Your receipt of KPIC's notice of the child's attainment of the limiting age and subsequently as may be required by KPIC, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

IMPORTANT:
KPIC will not deny enrollment of a child under the health insurance coverage of a child's parent because:
1. The child was born out of wedlock;
2. The child is not claimed as a Dependent on the parent's federal income tax return; or
3. The child does not reside with the parent or in an applicable service area.

Eligibility Date of Dependents
A Dependent's eligibility date is the later of: (a) Your eligibility date; or (b) the date the person qualifies as Your Dependent. A child named in a Qualified Medical Child Support Order qualifies as Your Dependent on the date specified in the court order. An adopted child qualifies as Your Dependent on the earlier of: the date of adoption or the date of Placement for Adoption.

Enrollment Rules for Eligible Employee or Dependent
If you are an Eligible Employee, your effective date of insurance is determined by the Enrollment Rules that follow. Your Dependent's effective date is likewise determined by the following Enrollment Rules:

ELIGIBILITY

1. Initial Open Enrollment

The Policyholder will offer an initial open enrollment to new Eligible Employees and Dependents when the Employee is first eligible for coverage.

Effective date. Initial enrollment for newly Eligible Employees and Dependents is effective following completion of any waiting period (not to exceed 90 days), if required by the Policyholder. In the absence of a waiting period, the enrollment becomes effective according to the eligibility rules established by the Policyholder

If You did not enroll Yourself and/or Your Dependents during the initial enrollment period, You will need to wait until the next annual open enrollment period to enroll or during the special enrollment period as described below.

2. Annual Open Enrollment

Annual open enrollment refers to a standardized annual period of time, of no less than 30 days prior to the completion of the employer's plan year for Eligible Employees and Dependents to enroll. During the annual open enrollment period, Eligible Employees and Dependents can apply for or change coverage by submitting an enrollment application to your Group during the annual open enrollment
period.

Effective date. Enrollment is effective on the first day following the end of the prior plan year. Annual open enrollment occurs only once every year. The Policyholder will notify You when the annual open enrollment is available in advance of such period. Your Group will let you know when the annual open enrollment period begins and ends and the effective date.

3. Special Enrollment

You or your Dependent may experience a qualifying event that allows a change in your enrollment. Examples of qualifying events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The qualifying event results in a special enrollment period that usually (but not always) starts on the date of the qualifying event and lasts for sixty (60) days. During the special enrollment period, you may enroll your Dependent(s) in this plan or, in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Kaiser Permanente and other requirements, call **Member Services a**t 1-855-364-3184.

Effective Date. In the case of birth, adoption, or placement for adoption, or placement in foster care, enrollment is effective on the date of birth, adoption, or placement for adoption or placement in foster care.

In the case of any other qualifying event, including marriage, civil union, or loss of coverage, enrollment is effective the first day of the following month after We received a fully completed enrollment form.

If You have Dependent coverage and there would be no extra cost for adding a Dependent to Your coverage, the effective date of insurance for a Dependent will be the date You acquire the Dependent. You must notify KPIC that You have a new Dependent within 31 days so that the Dependent can be added to Your coverage. This will also help avoid delays on any claim You might file on behalf of the Dependent.

If the cost of Your Dependent coverage would increase when You add a Dependent, You must enroll the Dependent for insurance and agree to pay any additional cost in accordance with the Enrollment Rules. The effective date of insurance for that Dependent will be the date determined from the Enrollment Rules. If a Dependent does not enroll when eligible during the special enrollment period he/she may be excluded from all coverage until the next Annual Open Enrollment Period.

ELIGIBILITY

Court or Administrative Ordered Coverage for a Dependent Child
If a Covered Person is a non-custodial parent and is required by an Order to provide health coverage for an eligible child and the Covered Person is eligible for coverage under a family plan, the Covered Person, employee, employer or group administrator may enroll the eligible child under family coverage by sending KPIC a written application and paying KPIC any additional amounts due as a result of the change in coverage. Enrollment period restrictions will not apply in these circumstances. However, the child should be enrolled within 31 days of the court or administrative order to avoid any delays in the processing of any claim that may be submitted on behalf of the child. Coverage will not commence until the enrollment process has been completed.

If the Covered Person, employee, administrator, or employer fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, district attorney, child's legal custodian or the State Department of Health Services may submit the application for insurance for the eligible child. Enrollment period restrictions will not apply in these circumstances. However, the child must be enrolled within 31 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

The coverage for any child enrolled under this provision will continue pursuant to the terms of this health insurance plan unless KPIC is provided written evidence that:
1. The Order is no longer in effect;
2. The child is or will be enrolled in comparable health coverage through another insurer which will take effect on or before the requested termination date of the child's coverage under the Group Policy;
3. All family coverage is eliminated for members of the employer group; or
4. Nonpayment of premium.

Newborns
A newborn Dependent child is insured from birth, whether or not You have applied for coverage, for a period of 31 days.

If You are already insured for Dependent coverage, no further application is required to continue the child's coverage. If You are not already insured for Dependent coverage and if an additional premium is required for the child's coverage, You must apply for and pay the additional premium before the expiration of the 31-day period; otherwise the child's coverage will terminate after the 31-day period.

Coverage for newborn children will include coverage for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If the newborn child is born with cleft lip or cleft palate or both, care and treatment will include to the extent Medically Necessary:
1. Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
2. Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
3. Orthodontic treatment;
4. Prosthodontic treatment;
5. Habilitative speech therapy;
6. Otolaryngology treatment; and
7. Audiological assessments and treatment.

Adopted Children
Your adopted child is insured for the period of 31 days after the earlier of the date of adoption or the date of Placement for Adoption, whether or not You have applied for coverage.

If You are already insured for Dependent coverage, no further application is required to continue the child's coverage. If, however, You are not already insured for Dependent coverage and You are required to pay an additional premium for the child's coverage, You must apply for and pay the additional premium before the expiration of the 31-day period: otherwise, the child's coverage will terminate after the 31-day period.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

This section describes how to access your services and how to obtain approval of certain benefits that are subject to Pre-certification.

Please read the following information carefully. It will help You understand how the prior authorization requirements and the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services.

Your coverage under the Group Policy includes coverage for Covered Services received from Participating Providers as well as Non-Participating Providers. Normally, benefits payable under the Group Policy are greater for Covered Services received from Participating Providers than those benefits payable for Covered Services received from Non-Participating Providers. In order for benefits to be payable at the Participating Provider level under the Participating Provider Tier, the Covered Person must receive care from a Participating Provider. To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Provider directory is available from Your employer or You may call the phone number listed on Your ID card or You may visit KPIC's web site at https://kp.org/kpic-colorado or KPIC's contracted provider network website at https://providerlocator.firsthealth.com/Kaiser. If a Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy will be payable at the Non-Participating Provider level at the Non-Participating Provider Tier. However, if there are no Participating Providers within a reasonable distance per state regulation to provide a covered benefit, and as a result services are provided by a Non-Participating Provider, then the service will be covered at the Participating Provider level. Please notify us by calling **Customer Service** at 1-855-364-3184 if you are unable to locate a Participating Provider for a covered benefit.

In addition to higher Deductibles, Coinsurance or Copayments, a Non-Participating Provider may balance bill you. Balance billing occurs when a Non-Participating Provider bills you for the difference between the billed amount and Maximum Allowable Charge. Non-Participating Providers rendering services in Colorado are not allowed to balance bill You in any of the following circumstances:

- When you receive Emergency services in a Non-Participating facility or when Emergency services are rendered by physicians and other professionals that are Non-Participating Providers.
- When you receive Non-Emergency Services rendered in Participating facilities by physicians and other professionals that are Non-Participating Providers.

NOTE: A Non-Participating Provider may balance bill you in the circumstances described above if you choose to use a Non-Participating Provider.

KPIC is not responsible for Your decision to receive treatment, services or supplies from Participating or Non-Participating Providers. Additionally, KPIC is neither responsible for the qualifications of providers nor the treatments, services or supplies under this coverage.

Pre-certification through the Medical Review Program

This sub-section under the **HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS** section describes:

1. The Medical Review Program and Pre-certification procedures for medical benefits other than Outpatient Prescription Drugs;
2. How failure to obtain Pre-certification affects coverage;
3. Pre-certification administrative procedures; and
4. Which clinical procedures require Pre-certification.

If Pre-certification is not obtained, benefits payable by KPIC, will be reduced by twenty percent (20%) each time Pre-certification is required. This 20% reduction will not count toward any Deductible, Coinsurance, or Out-of-Pocket Maximum applicable under the Group Policy. Such reduction only applies

if You receive services, which have not been pre-certified, from a Non-Participating Provider, subject to the **IMPORTANT** note stated below.

IMPORTANT: Consistent with applicable Colorado law, the sole responsibility for obtaining any necessary Pre-certification regarding the utilization of the Participating Provider level of benefits rests with the Participating Provider, who recommends or orders Covered Services, and not with the Covered Person.

If You, however, received services from a Non-Participating Provider, and Pre-certification is not obtained, benefits payable by KPIC will be reduced even if the treatment or service is deemed Medically Necessary. If the treatment or service is deemed not to be Medically Necessary, the treatment or service will not be covered. If a Hospital Confinement or other inpatient care is extended beyond the number of days first pre-certified without further Pre-certification, benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered, if deemed not to be Medically Necessary.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours a day, seven (7) days a week at 1-888-525-1533.

The following treatment or services must be pre-certified by the Medical Review Program when identified as a covered service (see the **SCHEDULE OF BENEFITS (Who Pays What)** section) under you plan:

1. All Inpatient admissions* and services including:
   a) Inpatient Rehabilitation Therapy Admissions including Comprehensive Rehabilitation Facility admissions related to services provided under an inpatient multidisciplinary rehabilitation program;
   b) Inpatient Mental Health and Substance Use Disorder admissions and services including Residential Services;
   c) Long Term Acute Care and Sub-acute admissions
2. Skilled Nursing Facility
3. Non-Emergent Air or Ground Ambulance Transport
4. Amino Acid-Based Elemental Formulas
5. Clinical Trial
6. Medical Foods
7. Applied Behavior Analysis (ABA)
8. Cardiac Rehabilitation
9. Dental and Endoscopic Anesthesia
10. Durable Medical Equipment
11. Genetic Testing
12. Habilitative Services (Physical Therapy, Occupational Therapy and Speech Therapy)
13. Home Health and Home Infusion Services
14. Hospice Care
15. Imaging Services (Magnetic Resonance Imaging or MRI, Magnetic Resonance Angiography or MRA, Computerized Tomography or CT, Computerized Tomography Angiography or CTA, Positron Emission Tomography or PET, Electron Beam Computerized Tomography or EBCT, Single Photon Emission Computerized Tomography or SPECT)
16. Infertility Services
17. Observation stays
18. Outpatient Injectable Drugs
19. Outpatient Procedures
20. Outpatient Surgery
21. Pain Management Services
22. Prosthetic and Orthotic Devices
23. Radiation Therapy Services
24. Reconstructive Surgery
25. Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy, Speech Therapy and Pulmonary Therapy)
26. TMJ/Orthognathic Surgery

27. Transplant Services including pre-transplant and post-transplant services
28. Transgender Surgery Services

*Pre-certification is not required for emergency admissions. You or Your attending Physician should notify the Medical Review Program of the admission not later than twenty-four (24) hours following an emergency admission or as soon as reasonably possible.

NOTE: The above list is subject to change. For the most current information, please call the Medical Review Program at 1-888-525-1553 or 711 (TTY).

Pregnancy Pre-certification: When a Covered Person is admitted to a Hospital for delivery of a child, the Covered Person is authorized to stay in the hospital not less than:
1. Forty-eight (48) hours for a normal vaginal delivery; or
2. Ninety-six (96) hours for a Cesarean section delivery.

A stay longer than the above may be allowed provided the attending provider obtain authorization for an extended confinement through KPIC's Medical Review Program. In no case will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited above. Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

Pre-certification Procedures
The Covered Person or the attending Physician must notify the Medical Review Program as follows:
1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three (3) days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally pre-certified.
3. Other treatments or procedures requiring Pre-certification - as soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Pre-certification but at least three days prior to performance of any other treatment or service requiring Pre-certification.
4. During the first trimester of pregnancy if the Covered Person intends to have Birth Services covered under this health insurance plan.
5. Hospital Confinement - as soon as reasonably possible upon stabilization following any emergency admission.

A Covered Person or the attending Physician must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:
1. Obtain a second opinion from a Physician selected from a panel of three (3) or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second surgical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning, and long-term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service.

If the Covered Person or the attending Physician does not provide the necessary information or will not release the necessary information within the prescribed period as provided in the **APPEALS and COMPLAINTS** section on Pre-Service Claim, We will make a decision based on the information We have.

Please refer to the **APPEALS AND COMPLAINTS** section on Pre-Service Claim of this Certificate of Insurance for Pre-certification request process. Also, refer to the same section where a benefit is denied, in whole or in part, due to a failure to obtain Pre-certification for services rendered by a Non-Participating Provider.

For prior authorization of certain Outpatient Prescription Drugs, please refer to the **BENEFITS/COVERAGE (What is Covered**) section under the Outpatient Prescription Drugs subsection.

BENEFITS/COVERAGE (What is Covered)

This section describes the **BENEFITS/COVERAGE (What is Covered)** provisions. See the **SCHEDULE OF BENEFITS (Who Pays What)** section to determine if the benefit is a covered service. General limitations and exclusions are listed in the **LIMITATIONS/EXCLUSIONS (What is Not Covered)** section.

Insuring Clause
Upon receipt of satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable (shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section) of the Maximum Allowable Charge for Covered Charges incurred to treat a covered Injury or Sickness, provided:

1. The expense is incurred while the Covered Person is insured for this benefit;
2. The expense is for a Covered Service that is Medically Necessary;
3. The expense is for a Covered Service prescribed or ordered by the attending Physician or those prescribed or ordered by any other providers, who are duly licensed by the State to provide medical services without the referral of a Physician;
4. The Covered Person has satisfied the applicable Deductibles, Coinsurance, Copayments, and other amounts payable; and
5. The Covered Person has not exceeded the Maximum Benefit While Insured or any other maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Payments under this Group Policy, to the extent allowed by law:

1. May be subject to the limitations shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section;
2. May be subject to the General Limitations and Exclusions; and
3. May be subject to Pre-certification.

Covered Services: Refer to the **DEFINITIONS** section for the meaning of capitalized terms. Unless specifically stated otherwise elsewhere in this Certificate of Insurance or in the **SCHEDULE OF BENEFITS (Who Pays What)** section, coverage is as follows:

Outpatient Care

1. Physicians' services including evaluation and management services during office visit or virtual care services consisting of Telehealth visits such as video visits; email/online visits; and telephone visits.
2. Nursing care by a Registered Nurse (RN) or, if none is available, as certified by the attending Physician, nursing care by a Licensed Vocational Nurse.
3. Services by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife, or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
4. Respiratory therapy rendered by a certified respiratory therapist.
5. Allergy testing materials and allergy treatment material.
6. Dressings, casts, splints.
7. Anesthesia and its administration by a licensed anesthesiologist or licensed nurse anesthetist.
8. Outpatient surgery or diagnostic procedures in a Free-Standing Surgical Facility or other licensed medical facility.
9. Hospital charges for use of a surgical room on an outpatient basis.
10. Pre-admission testing, limited to diagnostic, X-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made
11. Outpatient Birth Services in a Hospital, Birth Center or any other duly licensed facility. Pregnancy and Complications of Pregnancy will be covered on the same basis as any other physical Injury or Sickness.
12. Treatment of Intractable Pain, after reasonable efforts to cure or relieve the cause of the pain. Treatment for Covered Persons must be provided through one of the following:
    a. A primary care physician with documented experience in pain management and whose practice includes up-to-date treatment;

b. A pain management specialist who is located in the State of Colorado;
c. A reasonably requested referral to a pain management specialist, if applicable.

13. Outpatient self-management training and education related to the care of diabetes, including equipment and supplies and medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items in accordance with applicable Colorado law. When prescribed, diabetes outpatient self-management and education must be provided by a certified, registered, or licensed health care professional with expertise in the care of diabetes.
14. Chemotherapy Services
15. Non-Dental Services to treat Temporomandibular Joint (TMJ) disorder.
16. Chiropractic Care Spinal Manipulation Services and supplies regardless of the license the provider performing the Service holds.
17. Medically Necessary Bariatric Surgery Services
18. Fecal Microbiota Treatment
19. Necessary Services and Supplies.

Inpatient Hospital Care

1. Room and Board in a Hospital, such as semi-private room or private room when a Physician determines it is medically necessary.
2. Room and Board in a Hospital Intensive Care Unit.
3. Respiratory therapy rendered by a certified respiratory therapist.
4. Physicians' services.
5. Nursing care by a Registered Nurse (RN) or, if none is available, as certified by the attending Physician, nursing care by a Licensed Vocational Nurse.
6. Services by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife, or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
7. Private duty nursing services in an inpatient hospital when medically necessary.
8. Dressings, casts, splints.
9. Anesthesia and its administration by a licensed anesthesiologist or licensed nurse anesthetist.
10. Inpatient Birth Services in a Hospital, Birth Center or any other duly licensed facility. Pregnancy and Complications of Pregnancy will be covered on the same basis as any other physical Injury or Sickness.
11. Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) following a Cesarean section, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier. A stay longer than the above may be allowed provided the attending provider obtains Pre-certification for an extended confinement through KPIC's Medical Review Program. If the covered hospital stay for child birth ends after 8 p.m. coverage will be continued until 8 a.m. the following morning. In no case will KPIC require that a provider reduce the mother's or child's hospital confinement below the allowable minimum cited above.
12. Medically Necessary Bariatric Surgery Services
13. Necessary Services and Supplies.

Ambulance Services

1. Transportation by an ambulance service for Emergency Care.
2. Transportation by an ambulance service for non-Emergency Care when the use of other means of transportation would adversely affect Your condition.

Autism Spectrum Disorders

Coverage for Autism Spectrum Disorders (ASD) is provided. The following services are in addition to, and not in lieu of, Early Childhood Intervention Services, as provided for under this Policy. Also, Covered Services provided for ASD are in addition to any service, which may be covered and rendered to a Dependent pursuant to an Individualized Family Service Plan, and Individualized Education Program or an Individualized Plan.

Coverage for ASD includes the following:

1. Evaluation for treatment and assessment services;
2. Behavior Training and behavior management and Applied Behavior Analysis, including, but not

limited to: consultations, direct care, supervision or treatment, or any combination thereof;
3. Habilitative or Rehabilitative services;
4. Pharmacy Care which as covered under the Outpatient Prescription Drug benefit;
5. Psychiatric Care;
6. Psychological Care, including family counseling; and
7. Therapeutic Care.

The ASD Covered Services listed above, must be rendered in accordance with a Treatment Plan by an Autism Service Provider, as defined under this Policy. When rendered in accordance with a Treatment Plan, such Covered Services are considered to be appropriate, effective, and efficient for the purpose of treating ASD, and not to be regarded as either experimental or investigational.

Behavioral Health and Mental Health Services

Diagnosis, treatment, services, or supplies are covered under this Group Policy for Behavioral Health and Mental Health disorders, except Autism Spectrum Disorder or ASD, when received as an inpatient or on an outpatient basis in an office, Hospital, Residential Treatment facility or other licensed medical facility including a community mental health facility, and when diagnosed and treated by a provider duly licensed to diagnosis and treat such conditions. Coverage for Autism Spectrum Disorder or ASD is described under a separate header in this section.

Benefits will be limited to treatment, services or supplies otherwise covered under this Group Policy and will be provided on the same terms and conditions and no less extensive than, those provided for the treatment and diagnosis of other physical diseases or disorders.

Services include:
1. Inpatient Hospital services such as testing, treatment, therapy including electroconvulsive therapy, and counseling.
2. Partial hospitalization. Intensive and structured outpatient treatment offered for several hours during the day or evening. Services can be as intensive as inpatient care but do not require an overnight confinement in an inpatient hospital setting.
3. Outpatient and Office based services such as testing, treatment, therapy and counseling.

Clinical Trials

We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
1) We would have covered the Services if they were not related to a clinical trial.
2) You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a) A Physician makes this determination.
   b) You provide us with medical and scientific information establishing this determination.
3) If any Participating Provider participates in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.
4) The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b) The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c) The study or investigation is approved or funded by at least one of the following:
      i) The National Institutes of Health.
      ii) The Centers for Disease Control and Prevention.
      iii) The Agency for Health Care Research and Quality.
      iv) The Centers for Medicare & Medicaid Services.
      v) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.

vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
vii) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
   1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
   2. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the **SCHEDULE OF BENEFITS (Who Pays What)** section for the Cost Share that applies to hospital inpatient care.

Clinical trials exclusions
1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Dental Services
1. Hospitalization and Anesthesia for Dental Procedures. Covered Services includes hospitalization and general anesthesia administered to a covered Dependent child for dental procedures. The general anesthesia must be provided in a Hospital, outpatient surgical facility, or other licensed facility Treatment must be provided by an anesthesia provider who is either:
   a) An educationally qualified specialist in pediatric dentistry; or
   b) Any other dentist who is educationally qualified in a recognized dental specialty for which Hospital privileges are granted or who is certified by virtue of completion of an accredited program of post- graduate Hospital training to be granted Hospital privileges.

   In order for the child's hospitalization and general anesthesia to be covered, the child's treating dentist must provide a written opinion to KPIC indicating that:
   a) The Dependent child has a physical, mental, or medically compromising condition; or
   b) The Dependent child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
   c) The Dependent child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
   d) The Dependent child has sustained extensive orofacial and dental trauma.

This provision does not apply to treatment rendered for temporomandibular joint disorders.
This provision does not provide coverage for any dental procedure or the services of the dentist.

2. Medically necessary orthodontia limited to dental services within the mouth for treatment of a condition related to or resulting from cleft lip and/or cleft palate.

Dialysis Care
Dialysis services related to acute renal failure and end-stage renal disease including dialysis equipment; training; and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Drugs, Supplies and Supplements
1. Drugs and materials that require supervision or administration by medical personnel during a covered hospital confinement or other covered treatment.
2. Medical Foods, as defined, when related to the treatment of inherited enzymatic disorders caused by single-gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions include, but are not limited to the following diagnosed conditions:

phenylketonuria (PKU), maternal PKU, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia, propionic acidemia, immunoglobin E and immunoglobin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of gastrointestinal tract. Medical Foods may also be for home use, for which a Participating Physician has order a prescription, whether written, oral or electronic transmission. Except for PKU, there is no age limit on benefits for inherited enzymatic disorders, as specified above. The maximum age to receive benefits for PKU is twenty-one (21) years of age except that the maximum age to receive benefits for PKU for women, who are of child-bearing age, is thirty-five (35) years of age.

Outpatient Prescription Drugs

Covered Charges include charges for prescribed drugs or medicines or supplies purchased from a licensed pharmacy on an outpatient basis provided they:

a. Can be lawfully obtained only with the written prescription of a Physician or prescribing provider or dentist;
b. Are purchased by Covered Persons on an outpatient basis;
c. Are covered under the Group Plan; and
d. Do not exceed the maximum daily supply shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section, except that in no case may the supply be larger than that normally prescribed by a Physician or prescribing provider or dentist.

Such charges are subject to all of the terms and conditions of the Group Policy including Deductibles, Copayment, Coinsurance, exclusions and limitations, unless otherwise set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Drugs Covered:

Covered Charges for outpatient prescription drugs are limited to charges from a licensed pharmacy for:

1) Any medication whose label is required to bear the legend “Caution: federal law prohibits dispensing without a prescription.” Experimental drugs are not covered unless one or more of the following conditions are met:
   a) The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
   b) The drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.
2) A prescription legend drug for which a written prescription is required;
3) Non-injectable legend drugs (to include legend maintenance drugs). See exclusions list below for exceptions;
4) Compounded medication of which at least one ingredient is a legend drug;
5) Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber;
6) Legend prenatal vitamins.
7) Specialty Drugs such as self-administered injectable medications, as indicated in the Preferred Drug List, are covered, subject to the following conditions:
   a) The medication does not require administration by medical personnel;
   b) The administration of the medication does not require observation;
   c) The patient’s tolerance and response to the drug does not need to be tested, or has been satisfactorily tested; and
   d) The medication has been prescribed for self-administration at home.

   Self-administered injectable medications must be written on a prescription filled by a pharmacy, and self-administered by the patient or caregiver at home (not administered by providers in medical offices.
8) Prescribed oral anti-cancer medication, which has been approved by the Federal Food and Drug Administration, at a cost not to exceed the Coinsurance or the Copayment level as any intravenously administered or an injected anti-cancer medication prescribed for the same purpose.

9) Insulin and the following diabetic supplies, unless related to the Covered Service for outpatient self-management of diabetes as described in the **BENEFITS/COVERAGE (What is Covered)** section:
   a) Home glucose monitoring supplies are covered under Other Preventive Care section;
   b) Syringes and needles;
   c) Acetone and glucose test tablets; and
   d) Glucose test strips;
10) Prescription drugs and prescribed over the counter medicines for smoking cessation are covered under Your Preventive Care Services.
11) Prescription contraceptive drugs or devices are covered under Your Preventive Care Services.
12) Off-label use of drugs used for the treatment of cancer if the drug is recognized for the treatment of cancer in the authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Service.
13) Renewal of prescription eye drops when: (a) the request for renewal is made:(i) at least 21 days for a 30-day supply or (ii) at least 42 days for a 60-day supply or (iii) at least 63 days for a 90-day supply, from the later of the date the original prescription was dispensed or last renewed and (b) the original prescription states that additional quantities are needed and the renewal request does not exceed the number of additional quantities needed. One additional bottle (limited to one bottle every 3 months) of prescription eye drops is covered when: (a) the additional bottle is requested at the time the original prescription is filled; and (b) the original prescription states that it is needed for use in a day care center, school or adult day program.
14) A five-day supply of at least one of the FDA-approved drugs for the treatment of opioid dependence limited to a first (1st) request within a 12-month period.

Coverage under Other Policy Provisions: Charges for services and supplies that qualify as Covered Charges under this benefit provision will not qualify as Covered Charges under any other benefit provision of the Group Policy.

This Outpatient Prescription Drug Benefit uses an open Formulary. An open Formulary is a list of all FDA-approved drugs unrestricted drugs or devices unless specifically excluded under the plan. The Formulary consists of preferred generic and brand drugs and non-preferred generic and brand drugs and including specialty drugs. Please visit https://kp.org/kpic-colorado for the Drug Formulary

Your Outpatient Prescription Drug Benefit is subject to the following utilization management requirements.

Quantity Limits
Quantity limits apply to outpatient prescription drugs for safety and cost reasons and follow the manufacturer's FDA-approved guidelines from their package inserts. Prescribers must obtain authorization for quantities higher than those allowed under the utilization management program.

Age Limits
Age requirements/limits apply to some outpatient prescription drugs and are part of the utilization management program to help ensure You are receiving the right medication at the right time. Such limits restrict coverage for a drug to a certain age for reasons of safety and/or efficacy and as may be recommended to be necessary to promote appropriate use. In addition to age limitations determined by FDA-approved guideline, outpatient prescription drugs will be subject to requirements based on the recommendations of the U.S. Preventative Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC).

Step Therapy process
Selected prescription drugs require step therapy. Step therapy is a process that defines how and when a particular outpatient prescription drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through Your drug history, prior to the use of another drug (2nd line agent). The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain high-cost medications. Refer to the formulary for a complete list of medications requiring step therapy. This means that to receive coverage You may first need to try a proven, cost-effective medication before using a more costly medication. Treatment decisions are always between You and Your Prescribing Provider. Refer to the Formulary for a complete

list of medications requiring step therapy. The following outpatient prescription drugs shall not be subject to any Step Therapy requirement: (1) FDA-approved medication for the treatment of substance use disorder; (2) FDA-approved medication for the treatment of Stage four (4) advanced metastatic cancer; and (3) FDA-approved medication for the prevention of HIV infection when prescribed and dispensed by a pharmacist. For purpose of this provision medications for the prevention of HIV infection include pre-exposure, post exposure or other drugs approved by the FDA for the preventive of HIV infection.

Your Prescribing Provider should prescribe a first-line medication appropriate for Your condition. If Your Prescribing Provider determines that a first-line drug is not appropriate or effective for You, a second-line drug may be covered after meeting certain conditions.

Prior Authorization
Prior Authorization is a review and approval procedure that applies to some outpatient prescription drugs and is used to encourage safe and cost-effective medication use. Prior authorization is generally applied to outpatient prescription drugs that have multiple uses, are higher in cost, or have a significant safety concern. The following outpatient prescription drugs shall not be subject to Prior Authorization: (1) FDA-approved medication for the treatment of substance use disorder; and (2) FDA-approved medication for the prevention of HIV infection when prescribed and dispensed by a pharmacist. For purpose of this provision, medications for the prevention of HIV infection include pre-exposure, post-exposure or other drugs approved by the FDA for the prevention of HIV infection.

The purpose of Prior Authorization is to ensure that You receive the right medication for Your medical condition. This means that when Your Prescribing Provider prescribes a drug that has been identified as subject to Prior Authorization, the medication must be reviewed by the utilization management program to determine Medical Necessity before the prescription is filled. Prior authorization reviews address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires prior authorization, Your Prescribing Provider must work with Us to authorize the drug for Your use. Drugs requiring Prior Authorization have specific clinical criteria that You must meet for the prescription to be eligible for coverage. Refer to the Formulary for a complete list of medications requiring Prior Authorization. The most current formulary can be obtained by visiting https://kp.org/kpic-colorado. If You have questions about the Prior Authorization or about outpatient prescription drugs covered under Your plan, you can call 1-800-788-2949 (Pharmacy Help Desk) or 711 (TTY) 24 hours a day, 7 days a week (closed holidays).

Definitions specific to the Prior Authorization of Outpatient Prescription Drug and Step Therapy provisions:

"Prior Authorization" means certain covered outpatient prescription drugs will require an approval where the prescribed medication will be reviewed by Us to determine Medical Necessity before the prescription is filled. This approval process is called the prior authorization process.

"Urgent Prior Authorization Request" means:
A request for prior authorization when based on the reasonable opinion of the Prescribing Provider with knowledge of the Covered Person's medical condition, the time frames allowed for non-urgent prior authorization:

a. Could seriously jeopardize the life or health of the covered person or the ability to regain maximum function; or
b. The Covered Person is subject to severe pain that cannot be adequately managed without the drug benefit that is the subject of request for prior authorization.

"KPIC's Uniform Pharmacy Prior Authorization Request Form" means the standardized prescription drug prior authorization form prescribed by the Colorado Division of Insurance (DOI) that will be used under applicable Colorado state law and regulation.

"Prescribing Provider" means a provider licensed and authorized to write a prescription pursuant to applicable state law to treat a medical condition of a Covered Person.

When an outpatient prescription drug requiring Prior Authorization has been prescribed, You or Your Prescribing Provider must notify the utilization management program as follows:

1 Complete and submit KPIC's Uniform Pharmacy Prior Authorization Request Form available on-line at https://kp.org/kpic-colorado to the utilization management program as described in item 2 below. You or Your Prescribing Provider can also obtain a copy of KPIC's Uniform Prior Authorization Request Form by calling 1-800-788-2949. Prior authorization requests contained on a form other than KPIC's Uniform Pharmacy Prior Authorization Request Form will be rejected.

2. We will accept KPIC's Uniform Pharmacy Prior Authorization Request Form through any reasonable means of transmission, including, but not limited to, paper, electronic, or any other mutually accessible method of transmission, by sending it via fax at 1-858-790-7100.

3. Within one (1) business day upon Our receipt of a completed Urgent Prior Authorization Request, We will process the Urgent Prior Authorization Request and we will notify You or Your Prescribing Provider and dispensing pharmacy (if applicable) that:
   a) The request is approved; or
   b) The request is denied for any of the following reasons:
      (i) Not Medically Necessary;
      (ii) The patient is no longer eligible for coverage;
      (iii) The request is not submitted on the prescribed KPIC's Uniform Pharmacy Prior Authorization Request Form and must be resubmitted using the prescribed request form.
   c) There is missing material information necessary to determine Medical Necessity. We will notify and request Your Prescribing Provider to submit additional information needed to process the Urgent Prior Authorization Request.
      (i) Upon receipt of Our request for additional information, Your Prescribing Provider has a period of two (2) business days within which to submit the requested information; and
      (ii) Upon Our receipt of the requested additional information from Your Prescribing Provider, we shall make a determination within one (1) business day of receipt.
      (iii) However, upon failure by Your Prescribing Provider to submit the requested additional information within two (2) business days, the Urgent Prior Authorization Request shall be deemed denied; and
      (iv) We will provide You, Your Prescribing Provider or dispensing pharmacy (if applicable) with the confirmation of the denial within one (1) business day from the date the Urgent Prior Authorization Request was deemed denied.

4. Within two (2) business days upon receipt of a completed Non-Urgent Prior Authorization Request submitted electronically and within three (3) business days upon receipt of a completed Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation, We will process and notify You, Your Prescribing Provider and dispensing pharmacy (if applicable) that:
   a) The request is approved;
   b) The request is denied for any of the following reasons:
      (i) Not Medically Necessary;
      (ii) The patient is no longer eligible for coverage;
      (iii) The request is not submitted on the prescribed KPIC Uniform Pharmacy Prior Authorization Request Form and must be resubmitted using the prescribed request form.
   c) There is missing material information necessary to determine Medical Necessity. We will notify and request Your Prescribing Provider to submit additional information needed to process the Non-Urgent Prior Authorization Request.
      (i) Upon receipt of Our request for additional information, Your Prescribing Provider has a period of two (2) business days within which to submit the requested information; and
      (ii) Upon Our receipt of the additional information from your Prescribing Provider, We shall make a determination within two (2) business days for Non-Urgent Prior Authorization Request submitted electronically and within three (3) business days for Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation.

(iii) However, upon failure by Your Prescribing Provider to submit the requested additional information within two (2) business days, the Non-Urgent Prior Authorization Request shall be deemed denied.
(iv) We will provide You, Your Prescribing Provider and dispensing pharmacy (if applicable) with the confirmation of the denial within two (2) business days from the date the Non-Urgent Prior Authorization Request was deemed denied.

5. The Request shall be deemed to have been approved for failure on Our part to:
   a) Request additional information from Your Prescribing Provider; or
   b) To provide the notification of approval to You and Your Prescribing Provider; or
   c) To provide the notification of denial to You and Your Prescribing Provider within the required time frames set forth above from Our receipt of an Urgent Prior Authorization Request or a Non-Urgent Prior Authorization Request from Your Prescribing Provider.

6. We shall provide You, Your Prescribing Provider and the dispensing pharmacy (if applicable) with a confirmation of the deemed approval, as follows:
   a) For Urgent Prior Authorization Request - within one (1) business day of the date the request was deemed approved;
   b) For Non-Urgent Prior Authorization Request submitted electronically – within two (2) business days of the date the request was deemed approved; and
   c) For Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation – within three (3) business days of the date the request was deemed approved.

7. A Prior Authorization approval is valid for a period of one hundred eighty (180) days after the date of approval.

8. In the event Your Prescribing Provider's Prior Authorization Request is disapproved:
   a) The notice of disapproval will contain an accurate and clear written explanation of the specific reasons for disapproving the request.
   b) If the request is disapproved due to missing material information necessary to determine Medical Necessity, the notice of disapproval will contain an accurate and clear explanation that specifically identifies the missing material information.

9. Notices required to be sent to You or Your authorized representative or Your Prescribing Provider or dispensing pharmacy (if applicable) shall be delivered by Us in the same manner as the Prior Authorization Request Form was submitted to Us, or any other mutually agreeable accessible method of notification.

10. Prescription drug prior authorization procedures conducted electronically through a web portal, or any other manner of transmission mutually agreeable, shall not require You or Your Prescribing Provider to provide more information than is required by the KPIC's Uniform Pharmacy Prior Authorization Request Form.

Exception Requests for Prior Authorization, Step Therapy, Quantity and Age Limits

You or Your authorized representative or the Prescribing Provider may request an exception or a waiver to the Outpatient Prescription Drug Prior Authorization Request, Step Therapy process, Quantity and Age Limits described above if You are already being treated for a medical condition and currently under medication of a drug subject to Prior authorization or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition.

You may request to waive Step Therapy if the drug is on Our Formulary, You have tried the step therapy-required prescription drug while under Your current or previous health insurance and such prescription drugs were discontinued due to lack of effectiveness, diminished effect or an adverse event. We may require you to submit relevant documentation to support Your request.

However, further Prior Authorization may be required for the continued coverage of a prescription drug

prescribed pursuant to a Prior Authorization or Step Therapy process imposed from a prior insurance policy.

To request for an exception or waiver, please call:1-800-788-2949 (Pharmacy Help Desk).

If Your request for Outpatient Prescription Drug Prior Authorization or waiver of the Step Therapy process, Quantity and Age limits, is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **APPEALS AND COMPLAINTS** section for a detailed discussion of the grievance and appeals process and Your right to an External Review.

Exclusions for Outpatient Prescription Drug Benefits.

The following are not covered under the Outpatient Prescription Drug Benefit:

1) Internally implanted time-release medications, except contraceptives required by law;
2) Compounded dermatological preparation, which must be prepared by a pharmacist in accord with a Physician's prescription, with ingredients of which are available over the counter;
3) Antacids;
4) For Covered Persons with enterostomies and urinary diversions, the following ostomy supplies and equipment:
   a) Appliances;
   b) Adhesives;
   c) Skin barriers and skin care items;
   d) Belts and clamps;
   e) Internal and appliance deodorants;
5) Drugs when used for cosmetic purposes, including Ioniten (Minoxidil) for the treatment of alopecia, Tretinon (Retin A) for individuals 26 years of age or older and anti-wrinkle agents (e.g., Renova);
6) Non-legend drugs and non-legend vitamins;
7) Therapeutic devices or appliances, support garments and other non-medical substances, regardless of intended use, unless specifically listed above;
8) Charges for the administration or injection of any drug;
9) Drugs labeled "Caution - limited by federal law to investigational use." or experimental drugs, even though a charge is made to the individual, unless for the treatment of cancer as specified in item 1 under Drugs Covered;
10) Hematinics;
11) DESI Drugs - drugs determined by the FDA as lacking substantial evidence of effectiveness;
12) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institutions which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
13) Minerals;
14) Infertility medications;
15) Anorectic drugs (any drug used for the purpose of weight loss);
16) Fluoride supplements except as required by law.
17) Tobacco cessation products except as described under Preventive Care Services.

Dispensing Limitations: KPIC will not pay for more than the per prescription or refill supply set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section. In no case, however, may the supply be larger than that normally prescribed by a Physician or other lawful prescriber.

Direct Reimbursement

If you paid the full price for your prescription, you may request a direct reimbursement from us subject to the applicable Cost Share.

To submit a claim for direct reimbursement you may access the direct member reimbursement form via https://mp.medimpact.com/mp/public/Frameset.jsp?forwardUrl=/mp/public/HelpDesk.jsp to find the direct member reimbursement form or for assistance you may call the MedImpact Customer Contact Center 24 hours a day 7 days a week at 1-800-788-2949 (Pharmacy Help Desk) or email via customerservice@medimpact.com.

Mail Order

Check your **SCHEDULE OF BENEFITS (Who Pay What)** section to determine if you have mail order coverage. Certain maintenance medications are available by mail. A maintenance medication is a drug used on an ongoing basis. Not all maintenance medications are eligible for mail order such as controlled medications or those requiring refrigeration. If you have any questions about the mail order service please go online at walgreens.com/mailservice or call 1-866-525-1590 or 711 (TTY).

Durable Medical Equipment/External Prosthetics and Orthotics

1) Rental of Durable Medical Equipment. Purchase of such equipment may be made if in the judgment of KPIC:
   a) purchase of equipment would be less expensive than rental; or
   b) such equipment is not available for rental.
2) Prosthetic devices (External) are covered including:
   a) external prosthetics related to breast reconstruction resulting from a covered mastectomy;
   b) when necessary, to replace, in whole or in part, an arm or a leg; or
   c) required to treat cleft lip or cleft palate such as obturators, speech and feeding appliances.
3) Prosthetic devices (internally implanted) are covered as part of the surgical procedure to implant them.
4) Orthotics including diabetic shoes are covered. Repair or replacement of orthotic devices are covered when necessary due to growth. Arch supports and other devices for the foot, except for diabetic shoes, are not covered. Repair or replacement of orthotic devices due to loss or misuse is not covered.

Early Childhood Intervention Services

Eligible Insured Dependents, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for Early Intervention Services (EIS) up to the maximum number of visits as determined by the State.

Coverage of Early Childhood Intervention Services does not include any of the following:

1. Respite care;
2. Non-emergency medical transportation;
3. Service coordination, as defined by applicable Colorado law; and
4. Assistive technology that is not included as Durable Medical Equipment, which is otherwise covered under the Group Policy.

Emergency Services

Emergency Services are covered 24 hours a day, 7 days a week, anywhere in the world. If You have an Emergency Medical Condition, call 911 or go to the nearest emergency room.

If You receive Emergency Care/Services and cannot, at the time of emergency, reasonably reach a Participating Provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the Group Policy, at benefit levels at least equal to those applicable to treatment by a Participating Provider for emergency care.

Family Planning Services – See Preventive Care and Services

Hearing Services

1. Hearing exams and tests by audiologist needed to determine the need for hearing correction.
2. For Minor Dependents under the age of 18 with a verified hearing loss, coverage shall also include:
   a) Initial hearing aids and replacement hearing aids not more frequently than every five years;
   b) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Home Health Care

Home Health Services. The following services provided by a Home Health Agency under a plan of care to Covered Persons in their place of residence are covered:

a) Skilled nursing services;
b) Certified or licensed nurse aid services under the supervision of a Registered Nurse or a qualified therapist;
c) Physical therapy;
d) Occupational therapy;
e) Speech therapy and audiology;
f) Respiratory and inhalation therapy;
g) Nutrition counseling by a nutritionist or dietitian;
h) Medical social services;
i) Medical supplies;
j) Prosthesis and appliances suitable for home use;
k) Rental or purchase of durable medical equipment; and
l) Drugs, medicines, or insulin

Home health services do not include:
a) Food services or meals, other than dietary counseling;
b) Services or supplies for personal comfort or convenience, including Homemaker Services; and
c) Services related to well-baby care.

Covered Home Health Services are limited to intermittent care services. Intermittent care services means services are limited to 28 hours per week and less than 8 hours a day.

Such services must be provided in the Covered Person's home and according to a prescribed treatment plan established by a Physician in collaboration with the home health provider. Home health care must be required in lieu of hospitalization or in place of hospitalization. Services of up to four hours by a home health aide shall be considered as one visit.

Hospice Care

This provision only applies to a Terminally Ill Covered Person with a life expectancy of less than six (6) months receiving Medically Necessary care under a Hospice Care program. Benefits may exceed six (6) months should the Terminally Ill Covered Person continue to live beyond the prognosis for life expectancy. Covered Services include Hospice Care Benefits when a Covered Person's Physician provides KPIC a written certification of the Covered Person's Sickness along with a prognosis of life expectancy; and a statement that Hospice Care is Medically Necessary.

A copy of the Hospice program's treatment plan may be required before benefits will be payable.

Hospice Care benefits are limited to:
1. Physician services
2. Nursing care, including care provided by a Licensed Vocational Nurse or Certified Nurse's Aide, when under the supervision of a Registered Nurse or specialized rehabilitative therapist;
3. Physical, speech or occupational therapy and audiology;
4. Respiratory and inhalation therapy including oxygen and respiratory supplies;
5. Medical social services;
6. Nutrition counseling by a nutritionist or dietitian;
7. Rental or purchase of durable medical equipment;
8. Prosthetic and orthopedic appliances;
9. Medical supplies including drugs and biologicals;
10. Diagnostic testing necessary to manage the terminal illness;
11. Medically necessary transportation needed for hospice services;
12. Family counseling related to the Covered Person's terminal Sickness including bereavement support; and
13. Respite care.

Covered Persons who elect to receive Hospice Care are not entitled to any other benefits under the Group Policy for the terminal Sickness. Services and charges incurred by the Covered Person in connection with an unrelated illness will be processed in accordance with coverage provisions

applicable to all other illnesses and/or injuries.

No payments will be made for expenses that are part of a Hospice Care program that started after coverage under the Group Policy ceases.

Infertility Services

Services required to establish a diagnosis of infertility are covered. Services to treat infertility limited to the treatment of underlying medical conditions that cause infertility such as endometriosis and obstructed fallopian tubes are covered. Artificial insemination which includes intrauterine insemination (IUI) is covered.

Preventive Care Services

Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services. Please refer to Your **SCHEDULE OF BENEFITS (Who Pays What)** section regarding each benefit in this section:

As shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section as a Covered Service, the following Preventive Services are covered under this Policy and are not subject to Deductibles, Co-payments or Coinsurance if received from Participating Providers. Consult with Your physician to determine what preventive services are appropriate for You.

1. Exam:
   a) Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines
   b) Well woman exam visits including preconception counseling and routine prenatal office visits. Routine prenatal office visits include the initial and subsequent histories, physical examinations, recording of weight, blood pressure, fetal heart tones, and routine chemical urinalysis according to the Health Resources and Services Administration (HRSA) guidelines.

2. Screening:
   a) Abdominal aortic aneurysm screening
   b) Anxiety screening in adolescent and adult women, including those who are pregnant or post-partum
   c) Asymptomatic bacteriuria screening
   d) Breast cancer mammography screening
   e) Cervical dysplasia screening including HPV screening
   f) Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, over the counter and prescription drugs necessary to prepare the bowel for the procedure, and a specialist consultation visit prior to the procedure
   g) Depression screening
   h) Diabetes screening for non-pregnant women with a history of diabetes who have not previously been diagnosed with type 2 diabetes mellitus
   i) Gestational Diabetes screening
   j) Hepatitis B and Hepatitis C virus infection screening
   k) Hematocrit or Hemoglobin screening in children
   l) High blood pressure screening
   m) Lead Screening
   n) Lipid disorders screening to determine need for statin use
   o) Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screening (in adults who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. One pack year is equal to smoking one pack per day for one year, or two packs per day for half a year)
   p) Newborn congenital hypothyroidism screening
   q) Newborn hearing loss screening
   r) Newborn metabolic/hemoglobin screening
   s) Newborn sickle cell disease screening

t) Newborn Phenylketonuria screening
u) Obesity screening
v) Osteoporosis screening
w) Rh (d) incompatibility screening for pregnant women
x) Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis and HIV screening
y) Type 2 diabetes mellitus screening
z) Tuberculin (TB)Testing
aa) Urinary incontinence screening in women
bb) Visual impairment in children screening

3. Health Promotion:
   a) Unhealthy alcohol use and drug misuse screening or assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse.
   b) Healthy diet behavioral counseling
   c) Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
   d) Sexually transmitted infections counseling.
   e) Tobacco use screening, tobacco use and tobacco-caused disease counseling and interventions including behavioral interventions, FDA- approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs are also covered for women who are not pregnant and men. **NOTE:** There are resources available to You under the Colorado Quit Line. Please call 1-800-QUIT-NOW or visit its website at https://www.coquitline.org for more information.
   f) Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
   g) Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women, over age 35 with an increased risk of breast cancer and no history of breast cancer, risk reducing medication such as tamoxifen and raloxifene.
   h) When prescribed by a licensed health care professional authorized to prescribe drugs:
      (i) Aspirin in the prevention of cardiovascular disease, colorectal cancer and preeclampsia in pregnant women.
      (ii) Iron supplementation for children from 6 months to 12 months of age.
      (iii) Oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
      (iv) Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for prevention of dental caries in children.
      (v) Folic acid supplementation for women planning or capable of pregnancy.
   i) Interventions to promote breastfeeding: interventions during pregnancy and counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the postpartum period and the purchase of a breast pump. A hospital-grade electric breast pump, including any equipment that is required for pump functionality, is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
   j) All prescribed FDA-approved methods of contraception for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives and patches. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects; counseling for continued adherence, device removal, patient education and counseling. Over the counter FDA-approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs. The benefit will be provided as follows:
      (i) For a three-month period the first time the prescription contraceptive is dispensed; and
      (ii) For a twelve-month period or through the end of Your coverage whichever is shorter for any subsequent dispensing of the same prescription contraceptive regardless of whether You

were enrolled in the plan at the time the prescription coverage was dispensed.
(iii) For a three-month period for a prescribed vaginal contraceptive ring.
In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method.

k) Screening and counseling for interpersonal and domestic violence.
l) Physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
m) Counseling of parents of young children, children, adolescents, and young adults; from age 6 months to 24 years, who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
n) Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

4. Disease prevention:
   a) Immunizations as recommended by the Centers for Disease Control and HRSA including the cervical cancer vaccine as required under state law.
   b) Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum.
   c) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
      (i) individuals are aged 40-75 years;
      (ii) they have 1 or more cardiovascular risk factors; and
      (iii) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.
   d) Pre-exposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to persons who are at high risk of HIV acquisition effective July 1, 2020.

Preventive services may change upon Policy renewal according to federal guidelines in effect as of January 1 of each year in the calendar year in which this Group Policy renews. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services. For a complete list of current preventive services required under the Patient Protection Affordable Care Act please call: 1-800-464-4000. You may also visit: www.healthcare.gov/center/regulations/prevention.html. Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

Note: The following services are not Covered Services under this Preventive Exams and Services benefit but may be Covered Services elsewhere in this **BENEFITS/COVERAGE (What is Covered)** section:

- Lab, Imaging and other ancillary services associated with prenatal care not inclusive to routine prenatal care
- Non-routine prenatal care visits
- Non-preventive services performed in conjunction with a sterilization
- Lab, Imaging and other ancillary services associated with sterilizations
- Treatment for complications that arise after a sterilization procedure

5. Exclusions for Preventive Care
   a) Personal and convenience supplies associated with breast-feeding equipment, such as pads, bottles, and carrier cases;
   b) Replacement or upgrades of purchased breast-feeding equipment.

6. Other Preventive Care including:
   a. Adult physical exam.
   b. Annual Mental Wellness check-up.
   c. Prostate Screening as follows when performed by a qualified medical professional, including but not limited to a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or Physician assistant:
      i. For men age forty (40) through age forty-nine (49), one screening per Accumulation Period if

the Covered Person's Physician determines he is at high risk of developing prostate cancer; and

ii. For men age fifty (50) and older, one screening per Accumulation Period.

A prostate screening test consists of a prostate-specific antigen ("PSA") blood test and a digital rectal examination. Benefits are limited to a maximum payment of the lesser of the actual charge or $65 per screening and are exempt from any Deductibles.

d. Colorectal screening services are covered for:
   i. Asymptomatic average-risk adults, who are 50 years of age or older; and
   ii. Covered Persons, who are at high risk for colorectal cancer. Such high-risk Covered Persons include those individuals who have:
      1. A family medical history of colorectal cancer;
      2. A prior occurrence of cancer or precursor neo-plastic polyps;
      3. A prior occurrence of a chronic digestive disease condition, such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis, or other predisposing factors, as determined by a duly authorized provider.

   Benefits are provided for tests, as determined by a duly authorized provider that detect adenomatous polyps or colorectal cancer consistent with modalities that are included in "A" Recommendation or a "B" Recommendation of the Task Force.

e. Fecal DNA screening

f. Family planning services:
   i. Voluntary termination of pregnancy
   ii. Vasectomies

g. FDA-approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs for women who are pregnant.

h. Iron deficiency anemia screening for pregnant women

i. Expanded coverage of breast cancer screening services which includes:
   (1) The use of non-invasive imaging modality as recommended by the provider and within the appropriate use guidelines as determined by determined by the American College of Radiology and the National Comprehensive Cancer Network, for all individuals possessing at least one (1) risk factor for breast cancer including:
      (i) A family history of breast cancer;
      (ii) Being 40 years of age or older; or
      (iii) An increased lifetime risk of breast cancer determined by a risk factor model such as tyrer-cuzick, BRCAPRO, or GAIL by or other clinically appropriate risk assessment models.
   (2) Diagnostic imaging for further evaluation or supplemental imaging within the same policy year based on factors including a high lifetime risk for breast cancer or high breast density when deemed appropriate by the provider and the appropriate use guidelines as determined by determined by the American College of Radiology and the National Comprehensive Cancer Network.

j. The following services and items are covered as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
   (1) Hemoglobin A1C testing for individuals diagnosed with diabetes.
   (2) Retinopathy Screening for individuals diagnosed with diabetes.
   (3) Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
   (4) International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
   (5) Durable Medical Equipment items:
      (i) Peak flow meters for individuals diagnosed with asthma.
      (ii) Glucometers including lancets, strips, control solution and batteries for individuals diagnosed with diabetes.

Reconstructive Services

1. Reconstructive surgery including reconstruction of both the diseased and non-diseased breast after mastectomy to produce symmetrical appearance; and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

2. Treatment of Covered Persons, without regard to age, born with cleft lip and/or cleft palate, including the following procedures when found to be Medically Necessary: oral and facial surgery; surgical management and follow-up care by plastic surgeons and oral surgeons;
3. Treatment necessary for congenital hemangiomas and port wine stains.

Rehabilitation and Habilitation Services

1. Physical therapy to restore, keep, learn or improve skills or functioning. Therapy must be provided as prescribed by the attending Physician.
2. Speech therapy to restore, keep, learn or improve skills or functioning. This includes speech and language therapy and audiologic assessments and treatments for cleft lip and cleft palate.
3. Occupational therapy to restore, keep, learn or improve skills or functioning. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. Therapy must be provided as prescribed by the attending Physician.
4. Multidisciplinary rehabilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program to restore, keep, learn or improve skills or functioning.
5. Pulmonary therapy to restore respiratory function after an illness or injury.
6. Cardiac Rehabilitation.

Skilled Nursing Facility Care

Room and Board and other services rendered in a Skilled Nursing Facility. Care must follow a Hospital Confinement, and the Skilled Nursing Facility confinement must be the result of an Injury or Sickness that was the cause of the Hospital Confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved, and no further significant measurable improvement can be anticipated.

Substance Use Disorder Services

1. Inpatient services including services in a Residential Treatment facility and medical management of withdrawal symptoms in connection with Substance Use Disorder. Medical Services for alcohol and drug Detoxification are covered in the same way as for other medical conditions.
2. Outpatient treatment services including court-ordered services or supplies otherwise covered under the Group Policy if received in connection with Substance Use Disorder. Treatment is limited to a program of therapy in:
   (a) A facility established primarily for the treatment of Substance Use Disorder; or
   (b) A part of a Hospital used primarily for such treatment; or
   (c) (c) Any public or private facility providing services for the treatment of Substance Use Disorder, which is licensed by the Department of Health; or
   (d) Any mental health facility approved by the Department of Institutions.

Transgender Surgery Services:

Medically necessary surgery to treat gender dysphoria limited to genital surgery, mastectomy, tracheal shave and facial hair removal, is covered. Benefits for Covered Services, which are associated with transgender surgery are provided in the same manner as any other medical or surgical coverage, as set forth under this Certificate.

Transplant Services

Transplant services in connection with an organ or tissue transplant procedure, including charges incurred by a donor or prospective donor who is not insured under this Group Policy. Covered Charges will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. The Group policy will not cover any donor expenses, if the donor has coverage elsewhere that covers donor expenses.

Urgent Care Services

Treatment in an Urgent Care Center.

Vision Services

Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services.

Routine eye exams and refractive eye tests to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses.

All vision services not listed above are not covered, including but not limited to:
1. Laser Vision Correction
2. Orthoptics
3. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
4. Lenses, frames or contacts or their replacements.
5. Contact lens modification, polishing and cleaning.
6. Optical Hardware
7. Low vision aids

X-ray, Laboratory and Special Procedures
1. Diagnostic X-ray, pathology services and laboratory tests, Services and materials, including isotopes.
2. Diagnostic mammograms.
3. Electrocardiograms, electroencephalograms and mammograms.
4. Therapeutic X-ray Services and materials including radiation therapy. Radiation treatment is limited to:
   a) X-ray therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or
   b) the use of isotopes, radium or radon for diagnosis or treatment.
5. Special procedures such as MRI, CT, PET and nuclear medicine.

COVID-19 Services
Testing, treatment and other services that are related to COVID 19 to the extent required by applicable federal and state laws, regulations and bulletins.

LIMITATIONS/EXCLUSIONS (What is Not Covered)

No payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following, unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate, or in the **SCHEDULE OF BENEFITS (Who Pays What)** section, or any Rider or Endorsement that may be attached to the Group Policy. Refer to the **DEFINITIONS** section for the meaning of capitalized terms.

1. Charges in excess of the Maximum Allowable Charge.
2. Charges for non-Emergency Care in an Emergency Care setting.
3. Non-Emergency services outside the United States.
4. Weekend admission charges for non-Emergency Care Hospital services except when surgery is performed on the day of admission or the next day. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Confinement, treatment, services or supplies which are not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the Group Policy.
6. Confinement, treatment, services or supplies not prescribed, authorized or directed by a Physician or that are received while not under the care of a Physician.
7. Injury or Sickness for which the Covered Person has or had a right to payment under worker's compensation or similar law.
8. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third-party coverage.
9. Injury or Sickness arising out of, or in the course of, past or current work for pay, profit or gain, unless workers' compensation or benefits under similar law are not required or available.
10. Injury or Sickness contracted while on duty with any military, naval, or air force of any country or international organization.
11. Treatment, services, or supplies provided by: (a) the Covered Person; (b) the Covered Person's spouse, partner in a civil union or Domestic Partner; (c) a child, sibling, or parent of the Covered Person or of the Covered Person's spouse, partner in a civil union or Domestic Partner; or (d) a person who resides in the Covered Person's home.
12. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: (a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or (b) payment is required by law.
13. Dental care and dental X-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, including surgery on the jawbone and radiation treatment, except as provided for covered dependent children under the Hospitalization and Anesthesia for Dental Procedures provision and Medically necessary orthodontia for the treatment of cleft lip and palate.
14. Cosmetic Surgery, plastic surgery, or other services that are indicated primarily to improve the Covered Person's appearance and will not result in significant improvement in physical function. This exclusion does not apply to services that: (a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; (b) are incidental to a covered mastectomy; or (c) are necessary for treatment of congenital hemangioma and port wine stains.
15. Any drug, procedure or treatment for sexual dysfunction regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation.
16. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements even if prescribed or administered by a Physician.
17. Any treatment, procedure, drug, or equipment or device which KPIC determines to be experimental or investigational. This means that one of the following is applicable:
    a. The service is not recognized in accordance with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or used in testing or in other studies on human patients; or
    b. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

This exclusion will not apply to Clinical Trials covered in the **BENEFITS/COVERAGE (What is Covered)** section or to Routine Patient Care Costs related to clinical trials if the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has the potential to provide a therapeutic health benefit to the Covered Person.

18. Special education and related counseling or therapy, or care for learning deficiencies or behavioral problems. This applies whether or not the services are associated with manifest Mental Health disorder or other disturbances.
19. Services or supplies rendered for the treatment of obesity; however, Covered Charges made to diagnose the causes of obesity or charges made for treatment of diseases causing obesity or resulting from obesity are covered.
20. Confinement, treatment, services or supplies that are required:
    (a) Only for insurance, travel, employment, school, camp, government licensing, or similar purposes; or
    (b) Only by a court of law except when medically necessary and otherwise covered under the plan.
21. Personal comfort items such as telephones, radios, televisions, or grooming services.
22. Custodial care. Custodial care is: (a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or (b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
23. Intermediate care. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.
24. Routine foot care such as trimming of corns and calluses.
25. Confinement or treatment that is not completed in accordance with the attending Physician's orders.
26. Hearing Therapy except where Medically Necessary to treat cleft lip and cleft palate.
27. Hearing aids for adults age 18 and over.
28. Services of a private-duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility.
29. Outpatient private duty nursing services.
30. Acupuncture; biofeedback; massage therapy; or hypnotherapy.
31. Health education, including but not limited to: (a) stress reduction; (b) weight reduction; or (c) the services of a dietitian.
32. Medical social services except those services related to discharge planning in connection with: (a) a covered Hospital Confinement; (b) covered Home Health Agency Services; or (c) covered Hospice Care.
33. Living expenses or transportation, except as provided for under Covered Services.
34. Second surgical opinions, unless required under the Medical Review Program.
35. Eye refractions, orthoptics, contact lenses, or the fitting of glasses or contact lenses; radial keratotomy or any other surgical procedures to treat a refractive error of the eye, except as specified in the **BENEFITS/COVERAGE (What is Covered)** section for Vision services.
36. Reversal of sterilization.
37. Services provided in the home other than Covered Services provided through a Home Health Agency or related to Hospice Care services, as set forth under the **BENEFITS/COVERAGE (What is Covered)** section.
38. Repair or replacement of Prosthetics resulting from misuse or loss.
39. Treatment for infertility not otherwise covered in the **BENEFITS/COVERAGE (What is Covered)** and the **SCHEDULE OF BENEFITS (Who Pays What)** sections. Services not covered include: all Services and supplies (other than artificial insemination) related to conception by artificial means including but not limited to prescription drugs related to such Services, in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer, donor semen, donor eggs and Services related to their procurement and storage. These exclusions apply to fertile as well as infertile individuals or couples.
40. Maintenance therapy for rehabilitation.
41. Travel immunizations.
42. Non-human and artificial organs and their implantation.

43. Surrogate pregnancy and services in connection with a Surrogacy Arrangement if the surrogate mother is not a Covered Person. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. For Covered Persons in a Surrogacy Arrangement. please refer to "Surrogacy arrangements" under the **GENERAL POLICY PROVISIONS** section for information about your obligations to Us in connection with a Surrogacy Arrangement, including Your obligations to reimburse Us for any Covered Services We cover and to provide information about anyone who may be financially responsible for Covered Services the baby (or babies) receive.

NOTE: This plan does not impose any Pre-existing condition exclusion.

MEMBER PAYMENT RESPONSIBILITY

Deductible
Before any benefits will be payable during the Accumulation Period, a Covered Person must first satisfy the Deductible shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. Unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section, the Deductible applies to all Covered Services. The Deductible will apply to each Covered Person separately and must be met within each Accumulation Period. When Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person.

Payments under the Group Policy are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of Deductible and Coinsurance amounts and for Covered Services received from a Non-Participating Provider, any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the **DEFINITIONS** section.)

Self-Only Deductible
For a self-only enrollment (family of one Covered Person), there is only one Deductible known as Self-Only Deductible. When the Covered Person reaches his or her Self-Only Deductible, he or she will begin paying Copayments or Coinsurance.

Individual Deductible
For family enrollment (family of two or more Covered Persons), there is a Deductible for each individual family member known as Individual Deductible. Unless otherwise indicated in the **SCHEDULE OF BENEFITS (Who Pays What)** section or elsewhere in the Policy, the Accumulation Period Deductible as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section applies to all Covered Charges incurred by a Covered Person during an Accumulation Period. The Deductible applies separately to each Covered Person during each Accumulation Period. When Covered Charges equal to the Deductible are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. Benefits will not be payable for Covered Charges applied to the Deductible.

Family Deductible Maximum
The Deductible for a family has been satisfied for an Accumulation Period when a total of Covered Charges, shown in the **SCHEDULE OF BENEFITS (Who Pays What** section, has been applied toward the family members' Individual Deductibles.

If the Family Deductible Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section is satisfied in any one Accumulation Period by persons in covered family members, then the Individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Accumulation Period by any other person in Your family.

Benefit-specific deductibles
Some Covered Services are subject to additional or separate deductible amounts as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. These additional or separate deductibles do not contribute towards satisfaction of the Self-Only or Individual or Family Deductible.

NOTE: Please refer to the **SCHEDULE OF BENEFITS (Who Pays What)** section for the actual amount of Your Self-Only, Individual and Family Deductible.

Copayment/Coinsurance
You must pay any Copayment, Coinsurance as well as Deductibles for Covered Services. These Cost Shares are paid directly to the provider or facility. Copayment, Coinsurance and Deductible amounts are

listed in **SCHEDULE OF BENEFITS (Who Pays What**) section. If You receive Covered Services at a Participating Provider facility from a Non-Participating Provider not chosen by You, You are liable only for the Participating Provider Cost Share for the Covered Services You receive. In this circumstance. You are not liable for the difference between the Participating Provider Cost Share and the Non-Participating Provider's billed charges. If you receive a bill from a Non-Participating Provider in the circumstances described above, please call **Customer Service** at 1-855-364-3184 for assistance.

Out-of-Pocket Maximums
Any part of a charge that does not qualify as a Covered Charge, will not be applied toward satisfaction of the Out-of-Pocket Maximum.

Covered Charges applied to satisfy any Deductibles under this Group Policy count toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. Covered Charges applied to satisfy any Deductibles under this Group Policy do not count toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier.

Copayments and Coinsurance for Essential Health Benefits contribute toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. Coinsurance for Essential Health Benefits contribute toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier. Unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section Copayment amounts and pharmacy cost shares do not accumulate to the Out-of-Pocket Maximum at the Non-Participating Provider Tier.

Charges in excess of the Maximum Allowable Charge or Benefit Maximum and additional expenses a Covered Person must pay because Pre-certification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

Self-Only Out-of-Pocket Maximum
For a self-only enrollment (family of one Covered Person), there is only one Out-of-Pocket Maximum known as Self-Only Out-of-Pocket Maximum. When the Covered Person reaches his or her Self-Only Out-of-Pocket Maximum, he or she no longer pays Copayments or Coinsurance for those covered services that apply towards the Out-of-Pocket Maximum for the rest of the Accumulation Period.

Individual Out-of-Pocket Maximums
When the Covered Person’s Cost Share equals the Out-of-Pocket Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section during an Accumulation Period, the Percentage Payable will increase to 100% of further Covered Charges incurred by that same Covered Person for the remainder of that Accumulation Period.

Family Out-of-Pocket Maximums
When the family’s Cost Share equals the Out-of-Pocket Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section during an Accumulation Period, the Percentage Payable will increase to 100% of further Covered Charges incurred by all family members for the remainder of that Accumulation Period.

NOTE: Please refer to the **SCHEDULE OF BENEFITS (Who Pays What)** section for the actual amount of Your Self-Only, Individual and Family Out-of-Pocket Maximum.

Deductible and Out-of-Pocket Maximum Takeover Credit
Any Expenses Incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of Deductibles and Out-of-Pocket Maximums, as applicable, under the Group Policy if:
1. The expenses were incurred during the 90 days before the Effective Date of the Group Policy;
2. The expenses were applied toward satisfaction of the deductibles or Out-of-Pocket Maximum under the Prior Coverage during the 90 days before the Effective Date of the Group Policy; and
3. The expenses would be considered Covered Charges under the Group Policy.

MEMBER PAYMENT RESPONSIBILITY

For Group Policies with effective dates of coverage during the months of April through December, Expenses Incurred from January 1 of the current year through the effective date of coverage with KPIC may be eligible for credit.

For Group Policies with effective dates of coverage during the months of January through March, Expenses Incurred up to ninety (90) days prior to the effective date with KPIC may be eligible for credit.
You must submit all claims for the Deductible and Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with KPIC.

Prior Coverage means the Policyholder's group medical plan that the Group Policy replaced. KPIC will insure any eligible person under the Group Policy on its Effective Date, subject to the above provisions which apply only to Covered Persons who on the day before the Group Policy's Effective Date were covered under the Prior Coverage.

Maximum Allowable Charge
Payments under the Plan are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service from a Non-Participating Provider. (Refer to the definition of Maximum Allowable Charge shown in the **DEFINITIONS** section of the Certificate.)

Other Maximums
To the extent allowed by law, certain treatments, services and supplies are subject to internal limits or maximums. These additional items are shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

NOTE: Please refer also to the **SCHEDULE OF BENEFITS (Who Pays What)** section at the beginning of this Certificate of Insurance.

CLAIMS PROCEDURE (How to File a Claim)

All claims under the Group Policy will be administered by:

National Claims Administration - Colorado
PO Box 373150
Denver, CO 80237-9998
1-855-364-3184 (Toll-free)
711 (TTY)

Questions about Claims
For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call the number shown above, or You may write to the address shown above. Claim forms are available from Your employer.

You need to pay only Your Deductible and Coinsurance or Copayment.

Claim Filing Requirements
Set forth below is a description of Our claim filing requirements. You may also request a separate copy of Our claim filing requirements by writing to Us. We will respond to such requests within fifteen (15) calendar days. If We change any of the requirements, We will provide You with a copy of the revised requirements within fifteen (15) calendar days of the revision.

Claim Forms
We will provide the claimant with the notice of claim form. You must give Us written notice of claim within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon as reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. The notice should be mailed to Us at Our mailing address or to Our Claims Administrator at the address provided above.

When We receive Your notice of claim, We will send You forms for filing Proof of Loss. The forms may be obtained from and must be filed with KPIC's Administrator's office at the address set forth above. If We do not send You these forms within fifteen (15) days after receipt of Your Notice of Claim, You shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, the within the time limit stated in the Proof of Loss section. Clean Claims, as defined, will be paid, denied or settled within thirty (30) calendar days after receipt if submitted electronically, or within forty-five (45) calendar days, if the claim is submitted by any other means. If a claim is denied in whole or in part, the written notice of denial will contain: (1) reasons for the denial; (2) reference to the pertinent provisions of the Group Policy on which the denial is based; and (3) information concerning the Covered Person's right of appeal.

If additional information is required to complete the processing of Your Claim, We will request such information within thirty (30) calendar days after receiving Your Claim. We will provide a full explanation in writing as to what additional information is needed to resolve the claim from Your group or health care provider, or You. The person or entity receiving the request for additional information must submit all additional information to Us within thirty (30) calendar days after receiving the request. Under applicable Colorado law, We may deny a claim if You and/or the provider fail to submit the requested additional information in a timely manner. Absent fraud, all claims, except those considered to be Clean Claims, shall be paid, denied, or settled within ninety (90) calendar days after receipt by KPIC.

If the Covered Person is dissatisfied with the results of a review, the Covered Person may request a reconsideration. The request must be in writing and filed with KPIC's Administrator at the address set forth above. The written request for reconsideration must be filed within thirty (30) days after the notice of denial is received. A written decision on reconsideration will be issued within thirty (30) days after KPIC's Administrator receives the request for reconsideration.

CLAIMS PROCEDURE (How to File a Claim)

Proof of Loss
Written Proof of Loss must be sent to Us or to Our Administrator at the address shown on the preceding page within ninety (90) days after the day services were received. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible., but in no event, later than one year from the time proof is otherwise required, except in the absence of legal capacity. If You receive services from a Participating Provider, that provider will normally file the claim on Your behalf. At Your option, You may direct, in writing to KPIC, that benefits be paid directly to the provider.

Payment of Benefits
Benefits will be payable to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof of loss. The Covered Person, at his or her option, may assign, in writing to KPIC, all or part of such benefits directly to a person or institution on whose charges a claim is based.

A Covered Person may also authorize KPIC to pay benefits directly to a person or institution on whose charges a claim is based. Any such payments will discharge KPIC to the extent of payment made. Unless allowed by law, KPIC's payments may not be attached, nor be subject to, a Covered Person's debts.

At the Covered Person's option, any benefits for health expenses for covered medical transportation services may be assigned, in writing to KPIC, to the provider of these services. No benefits are payable to the Covered Person to the extent benefits for the same expenses are paid to the provider.

KPIC shall not retroactively adjust a claim based on eligibility if:
(1) The provider received verification of eligibility within two (2) business days prior to delivery of services unless the Policyholder notified KPIC:
    (a) That Employee is no longer eligible;
    (b) That Policyholder no longer intends to maintain coverage for the Group;
    (c) Within ten (10) business days after the date that Employee is no longer eligible or covered because the employee left employment without notice to the Policyholder/Employer or employment was terminated because of gross misconduct
(2) The provision of benefit is a required policy provision pursuant to state law unless the Policyholder notified KPIC of Employee's ineligibility within the timeframe provided in (1) (c).

Reimbursement of Providers
Reimbursement for services covered under this health insurance plan which are lawfully performed by a person licensed by the State of Colorado for the practice of osteopathy, medicine, dentistry, optometry, psychology, chiropractic, or podiatry shall not be denied when such services are rendered by a person so licensed. Licensed persons shall include registered professional nurses and licensed Clinical Social Workers within the scope of professional nursing or licensed social worker practice.

Legal Actions
No action at law or in equity may be brought to recover under the Group Policy prior to the expiration of sixty (60) days after the claim has been filed as required by the Group Policy. Also, no action may be brought after three (3) years from the expiration of the time within which proof of loss is required by the Group Policy.

Time Limitations
If any time limitation provided in the Group Policy for giving notice of claims, or for bringing any action at law or in equity, is less than that permitted by the applicable law, the time limitation provided in the Group Policy is extended to agree with the minimum permitted by the applicable law.

Assignment of Benefits to Colorado Department of Social Services
If a Covered Person receives medical assistance from the State of Colorado, under Colorado law, the State is deemed to have an assignment on all benefit payments made for medical expenses on behalf of

the Covered Person or any other covered family member. The assignment remains in effect as long as the individual is eligible for and receives medical assistance benefits from the State. This means that KPIC may pay benefits directly to the State when KPIC is aware that the Covered Person is a medical assistance recipient. Any payments made by KPIC in good faith pursuant to the State's assignment will fully discharge KPIC's obligation to the extent of the payment.

NOTE: For general information on claims, and how to submit Pre-Service Claims, Concurrent Care Claims, and Post-Service Claims, see the **APPEALS AND COMPLAINTS** section. For covered Services by Non-Participating Providers, you may need to submit a claim on your own. Contact **Customer Service** for more information on how to submit such claims.

GENERAL POLICY PROVISIONS

Time Effective
The effective time for any dates used is 12:01 a.m. at the address of the Policyholder.

Incontestability
Any statement made by the Policyholder or a Covered Person in applying for insurance under this Policy will be considered a representation and not a warranty. Its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement as determined by a court of competent jurisdiction. Only statements that are in writing and signed by the Policyholder and/or Covered Person may be used in a contest.

This Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue and that no statement made for the purpose of effecting insurance coverage under the policy with respect to a person shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits under such policy after such insurance has been in force for a period of two years during the lifetime of the Covered Person unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to the person making the statement or to the beneficiary of any such person.

Misstatement of Age
If the age of any person insured under this health insurance plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

Medical Examination and Autopsy
KPIC, at its own expense, shall have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Money Payable
All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

Rights of a Custodial Parent
If the parents of a covered Dependent child are:
1. Divorced or legally separated; and
2. Subject to the same Order,

The custodial parent will have the rights stated below without the approval of the non-custodial parent. However, for this provision to apply, the non-custodial parent must be a Covered Person approved for family health coverage under the Policy, and KPIC must receive:
1. A request from the custodial parent, who is not a Covered Person under the policy; and
2. A copy of the Order.

If all of these conditions have been met, KPIC will:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the Policy;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until We determine that:
1. The Order is no longer valid;
2. The Dependent child has become covered under other health insurance or health coverage;
3. In the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
4. The Dependent child is no longer a Covered Person under the Policy.

Termination by KPIC
KPIC may terminate the Group Policy or any insurance under the Group Policy on any premium due date by giving no less than 31 days written notice when the Policyholder:
1. Fails to pay premiums or contributions in accordance with the plan provisions, or KPIC does not receive premium payments in a timely manner; or
2. Commits an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the Group Policy; or
3. Fails to comply with a material health benefit plan contract provision, including contribution or group participation rules; or
4. No longer has any Covered Persons living, residing or working in the service area of the Preferred Provider Organization with respect to a Group Policy providing coverage, in whole or in part, in connection with a Preferred Provider plan.

If KPIC decides to discontinue offering this particular health benefit plan in the group market, KPIC may discontinue all coverage under the Group Policy. KPIC will give written notice of this type of nonrenewal to each Policyholder 90 days before the date coverage terminates. KPIC will offer each Policyholder whose coverage is discontinued the option to purchase another group health benefits plan currently offered by KPIC in the applicable state without regard to any health status-related factor of any Covered Person, including any individuals who may become eligible for the replacement coverage. Health benefit plan under this section means a particular product and not a plan design.

If KPIC stops offering all health insurance coverage in the group market, in the applicable state, KPIC has the right not to renew all policies issued on this form. KPIC will give written notice of this type of nonrenewal to the Policyholders and all Covered Persons 180 days before the date coverage terminates. Notice to an Insured Employee will be deemed notice to the Insured Dependents of that Insured Employee.

The Policyholder will be liable for all unpaid premiums for the period during which the Group Policy was in force with respect to any Covered Person whose coverage terminates.

Completion of Covered Services by a Terminated Provider
If You are inpatient in a Hospital, Skilled Nursing Facility, or a hospice for Hospice Care at the time of a Participating Provider's termination, You will continue to receive coverage for Covered Services until Your date of discharge from such inpatient facility consistent with applicable Colorado law.

As to services other than inpatient services, We will advise You in writing as to the specific extension of time, under Colorado law, pertaining to the rendition of Covered Services by a terminated Participating Provider

Coordination of Benefits Provisions Application
This Coordination of Benefits ("COB") provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order-of- benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

GENERAL POLICY PROVISIONS

Definitions Related to Coordination of Benefits

A. A "**plan"** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The **order-of-benefit payment rules** determine whether this plan is a "Primary plan" or "Secondary plan" when compared to another plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable Expense** is a health care service or expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service or portion of an expense that is not covered by any of the Plans covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If a Covered Person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the

basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Claim determination period** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

F. **Closed Panel Plan** is a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-of-Benefit Payment Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. (1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always Primary unless the provisions of both Plans state that the complying Plan is Primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is

determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
  (i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
  (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
  (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
  (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    • The Plan covering the custodial parent;
    • The Plan covering the spouse of the custodial parent;
    • The Plan covering the non-custodial parent; and then
    • The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Covered Person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a Covered Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the Covered Person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

A. When this Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The claims administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The claims administrator need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under this Plan must give the claims administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, the claims administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The claims administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the claims administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Surrogacy arrangements

If You enter into a Surrogacy Arrangement and You or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, You must reimburse Us for covered Services You receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") except that we will recover no more than half of the monetary compensation you receive. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" provision does not affect Your obligation to pay Your Cost Share for these Covered Services. After You surrender the baby to the legal parents, You are not obligated to reimburse Us for any Covered Services that the baby receives after the date of surrender (the legal parents are financially responsible for any Covered Services that the baby receives).

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments.

Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, You must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian
Kaiser Permanente
Surrogacy Mailbox
P.O. Box 36380
Louisville KY 40233

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy arrangements" section without our prior, written consent.

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

If You have questions about Your obligations under this provision, please contact **Customer Service** at 1-855-364-3184.

TERMINATION/NON-RENEWAL/CONTINUATION

Termination of an Insured Employee's Insurance
Except as provided in the Continuation of Medical Benefits provision, Your insurance will automatically terminate on the earlier of:

1. The date You cease to be covered by KPIC;
2. The date the Group Policy is terminated;
3. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. The end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion; or
5. The last day of the month You cease to qualify as an Eligible Employee.

In no event will Your insurance continue beyond the earlier of the date Your employer is no longer a Policyholder and the date the Group Policy terminates.

Termination of Insured Dependent Coverage
An Insured Dependent's coverage will end on the earlier of:

1. The date You cease to be covered by KPIC;
2. The last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. The date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;
4. The end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
5. The date the Group Policy is terminated;
6. The date the Dependent, or the Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
7. The date the Dependent relocates to a place outside of the geographic service area of a provider network, if applicable, unless specifically provided otherwise in the Group Policy.

Medically Necessary Leave of Absence for Student Dependent
If You, as a Dependent, are enrolled in a post-secondary educational institution, Your coverage will not terminate due to a Medically Necessary Leave of Absence before the date that is the earlier of: (a) one year after the first day of the Medically Necessary Leave of Absence or (b) the date coverage would otherwise terminate under the terms of the Group Policy.

Continuation of Coverage during Layoff or Leave of Absence
If Your full-time work ends because of a disability, an approved leave of absence or layoff, You may be eligible to continue insurance for Yourself and Your Dependents up to a maximum of three (3) months if full- time work ends because of disability or two (2) months if work ends because of layoff or leave of absence other than family care leave of absence. These provisions apply as long as You continue to meet Your Group's written eligibility requirements and This health insurance plan has not terminated. You may be required to pay the full cost of the continued insurance during any such leave.

Rescission for Fraud or Intentional Misrepresentation
Subject to any applicable state or federal law, if KPIC makes a determination that You performed an act, practice or omission that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Group Policy, KPIC may rescind Your coverage under the Group Policy by giving You no less than thirty-one (31) days advance written notice. The rescission will be effective, on:

1. The effective date of Your coverage, if we relied upon such information to provide coverage; or
2. The date the act of fraud or intentional misrepresentation of a material fact occurred, if the fraud or intentional misrepresentation of a material fact was committed after the Effective Date of Your coverage.

If Your or Your Dependent's Policy is rescinded, you have the right to appeal the rescission. Please refer to the **APPEALS AND COMPLAINTS** section of this Certificate for a detailed discussion of the

grievance and Appeals process and Your right to an Independent External Review.

CONTINUATION OF MEDICAL BENEFITS (FEDERAL)

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA).

Eligibility for Continued Health Coverage

A Covered Person whose group health coverage under the policy would end due to a qualifying event may have a right to elect continued Health Coverage for a limited period.

The phrase "health coverage" means the benefits of the policy that are based on Expenses Incurred for medical care.

A "Qualifying Event" is any one of the following events if it would cause the Covered Person to lose health coverage under the policy:

"A" The death of the covered employee;

"B" The termination (other than by reason of the covered employee's gross misconduct), or reduction in hours, of such employee's employment;

"C" The divorce or legal separation of the covered employee and his or her spouse, partner in a civil union or Domestic Partner;

"D" The covered employee's becoming entitled to Medicare benefits;

"E" A child's ceasing to be an eligible Dependent under the terms of this health insurance plan.

Written Notices and Election Required

Covered Persons must notify their employers of a qualifying event set forth in "C" or "E". That notice must be given within sixty (60) days after the event occurs. If such timely notice is not given, the event will not entitle the Covered Person to continued health coverage.

The employer will notify Covered Persons who become entitled to elect continued health coverage. That notice will be furnished within fourteen (14) days of: (a) the date timely notice of a qualifying event set forth in "C" or "E" is received; or (b) the date any other qualifying event occurs. If that notice from the employer is not given or is late, the qualifying event will not entitle the Covered Person to continued health coverage. Should a court or government agency require KPIC to pay any benefits as though coverage had been continued, the employer will reimburse KPIC in the full amount that KPIC is required to pay.

A Covered Person will have sixty (60) days in which to elect continued health coverage. That sixty (60) days starts with the later of: (a) the date the qualifying event would cause the Covered Person to lose health coverage under this health insurance plan; or (b) the date the employer provides timely notice to the Covered Person of his or her right to elect continued health coverage. A Covered Person who does not make a timely written election will not receive continued health coverage unless included as a spouse, partner in a civil union or Domestic Partner or child in another family member's timely election.

Effect of Other Continuations

If this health insurance plan otherwise provides any health coverage after a qualifying event: (a) such coverage that is not an option will not defer or extend the maximum period of continued health coverage in this provision; and (b) such coverage that is an elected option will be deemed a waiver of continued health coverage under this provision. However, if a covered employee elects such alternate health coverage for a spouse, partner in a civil union or Domestic Partner or child; and while that coverage is in effect another qualifying event occurs; then the alternate health coverage for the spouse, partner in a civil union or Domestic Partner or child will not end sooner than it would have under this provision.

Payment for Continued Health Coverage

The employer may require a Covered Person to pay for this continued health coverage. That payment will not exceed 102 percent of the total employer and employee cost of providing the same benefits to a Covered Person who has not had a qualifying event. The Covered Person will not be required to make such payments less frequently than monthly

Benefits under Continued Health Coverage
This continued health coverage will at all times provide the same health care benefits as would have been afforded to the Covered Person had a qualifying event not occurred. This includes any changes in the health coverage under this health insurance plan as may become effective while continued health coverage is in effect.

Termination of Continued Health Coverage
A Covered Person's continued health coverage under this provision will end at the earliest of the following dates:

1. The date which ends the "Maximum Period" as defined below;
2. The date that This Plan no longer covers the employer that sponsored the coverage before the Qualifying Event;
3. The date ending the last period for which the Covered Person has made any required payment for continued Health Coverage on a timely basis; or
4. The date after electing continued Health Coverage on which the Covered Person first becomes: a) covered under any other group health plan (as an employee or otherwise) which does not exclude or limit any pre-existing condition of the Covered Person; or b) entitled to Medicare benefits.

The "Maximum Period" referred to above will start with the date of the Qualifying Event and will end: (a) with the date eighteen (18) months after a qualifying event set forth in "B"; or (b) with the date thirty-six (36) months after any other Qualifying Event. In applying this maximum period, if continued health coverage is already in effect when a qualifying event other than as set forth in "B" occurs, the maximum period will not end less than thirty-six (36) months from the date of the original qualifying event; and if a Qualifying Event set forth in "D" occurs, the Maximum Period as to the Covered Employee's spouse, partner in a civil union or Domestic Partner or child for that or any subsequent Qualifying Event will not end less than thirty-six (36) months from the date the Covered Employee became entitled to Medicare benefits.

Extension for Disabled Covered Persons
If Social Security, under its rules, determines that a Covered Person was disabled when a Qualifying Event set forth in "B" occurred, the 18-month maximum period of continued health coverage for such a Qualifying Event may be extended to twenty-nine (29) months. To obtain that extension, the Covered Person must notify the employer of Social Security's determination before the initial 18-month maximum period ends.

For the continued health coverage of disabled Covered Persons that exceeds eighteen (18) months, KPIC may increase the premium it charges by as much as 50 percent. The employer may require the disabled Covered Persons to pay all or part of that total increased premium.

In no event will continued Health Coverage extend beyond the first month to begin more than thirty (30) days after Social Security determines that the Covered Person is no longer disabled. The Covered Person must notify the employer within thirty (30) days of the date of such a Social Security determination.

Continued Health Coverage from a Prior Plan
Continued Health Coverage will also be provided if: (a) this health insurance plan replaced a prior benefit plan of the employer or an associated company; and (b) a person's continued health coverage under a provision of that prior plan similar to this ended due to the replacement of that prior plan. In such case, that person may obtain continued Health Coverage under this provision. It will be as though this health insurance plan had been in effect when the Qualifying Event occurred. But no benefits will be paid under this health insurance plan for health care Expenses Incurred before its effective date.

Continued Health Coverage under Uniformed Services Employment and Reemployment Rights Act (USERRA)
If You are called to active duty in the uniformed services, You may be able to continue Your coverage under this Policy for a limited time after You would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to Your Employer within 60 days after Your call

to active duty.

Please contact Your Employer to find out how to elect USERRA coverage and how much You must pay Your Employer.

CONTINUATION OF MEDICAL BENEFITS (STATE)

Continuation of Health Coverage
A Covered Person must be given the option to elect continuation of this health insurance plan for himself or herself and any Dependents if:

1. The Covered Person's eligibility to receive coverage has ended for any reason other than discontinuance of the Group Policy in its entirety or with respect to an insured class;
2. Any premium or contribution required from or on behalf of the Covered Person has been paid to the termination date; and
3. The Covered Person has been continuously insured under the Group Policy, or under any Group Policy providing similar benefits which it replaces, for at least six (6) months immediately prior to termination.

A Covered Person has the right to continue coverage for: (a) a period of eighteen (18) months after termination of employment; or (b) until the Covered Person becomes re-employed, whichever occurs first. Should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen (18) months or until the new plan covers the condition, whichever occurs first.

The Covered Person must elect to continue coverage and pay the applicable amount to apply toward the premium within twenty (20) days after termination of employment. If proper notification is not given to the Covered Person, the Covered Person may elect to continue coverage and pay the applicable amount to apply toward the insurance within thirty (30) days after termination of employment.

Reduced Work Hours
The Policyholder may elect to contract with KPIC to continue coverage under the same conditions and for the same premium for Covered Person, even if the Policyholder reduces the working hours of such Covered Person to less than thirty (30) hours per week, provided the following conditions are met:

1. The Covered Person has been continuously employed as a full-time employee of the Policyholder and has been insured under the Group Policy or any Group Policy providing similar benefits which said policy replaces, for at least 6 months immediately prior to such reduction in working hours;
2. The Policyholder has imposed such reduction in working hours due to economic conditions; and
3. The Policyholder intends to restore the Covered Person to a full 40-hour work schedule as soon as economic conditions improve.

APPEALS AND COMPLAINTS

Claims and Appeals
KPIC will review claims and appeals, and We may use medical experts to help Us review them. The following terms have the following meanings when used in this "**APPEALS and COMPLAINTS**" section:

1. A **Claim** is a request for us to:
   a. Pay for a Service that You have not received (Pre-Service claim),
   b. Continue to pay for a Service that You are currently receiving (Concurrent Care Claim), or
   c. Pay for a Service that you have already received (Post-Service claim).

2. An **Adverse Benefit Determination** is Our decision to do any of the following:
   a. Deny Your Claim, in whole or in part, including:
      i) A denial, in whole or in part, of a Pre-Service Claim (preauthorization for a Service), a Concurrent Care Claim (continue to provide or pay for a Service that You are currently receiving) or a Post-Service Claim (a request to pay for a Service) in whole or in part; or
      ii) A denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or
      iii) A denial of a request for Services on the ground that the Service is experimental or investigational.
   b. Terminate Your coverage retroactively except as the result of non-payment of premiums (also known as Rescission or Retroactive Cancellation), or
   c. Uphold Our previous Adverse Benefit Determination when You appeal.

   In addition, when We deny a request for medical care because it is excluded under this policy and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then Our denial shall be considered an adverse benefit determination.

3. An **Appeal** is a request for Us to review Our initial Adverse Benefit Determination.

If You miss a deadline for making a Claim or Appeal, We may decline to review it.

Except when simultaneous External Review can occur, You must exhaust the Internal Claims and Appeals Procedure as described below in this **"APPEALS and COMPLAINTS"** section unless We fail to follow the claims and appeals process described in this Section.

If You miss a deadline for making a Claim or Appeal, We may decline to review it.

Except when simultaneous External Review can occur, You must exhaust the Internal Claims and Appeals Procedure as described below in this **"APPEALS and COMPLAINTS"** section unless We fail to follow the claims and appeals process described in this Section.

Language and Translation Assistance
You may request language assistance with Your Claim and/or Appeal by calling **Member Services** at 1-800-632-9700 or 711 (TTY).

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-632-9700.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-632-9700.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-632-9700.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-9700.

APPEALS AND COMPLAINTS

Appointing a Representative

If You would like someone including your provider (medical facility or health care professional) to act on Your behalf regarding Your Claim, You may appoint an authorized or designated representative. You must make this appointment in writing. Please contact **Customer Service** at 1-855-364-3184 or 711 (TTY) for information about how to appoint a representative. You must pay the cost of anyone You hire to represent or help You.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim

If You want to review the information that We have collected regarding Your Claim, You may request, and We will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling **Member Appeals Program** at 1-888-370-9858 or 1-303-344-7933 or 711 (TTY).

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact **Customer Service** at 1-855-364-3184 or 711 (TTY).

Providing Additional Information Regarding Your Claim and/or Appeal

When You appeal, You may send Us additional information including comments, documents, and additional medical records that You believe support Your Claim. If We asked for additional information and You did not provide it before We made Our initial decision about Your Claim, then You may still send Us the additional information so that We may include it as part of Our review of Your Appeal, if You ask for one. Please send all additional information to the Department that issued the Adverse Benefit Determination.

When You appeal, You may give testimony in writing or by telephone. Please send Your written testimony to **Appeals Program**. To arrange to give testimony by telephone, you should contact **Appeals Program a**t 1-888-370-9858 or 1-303-344-7933 or 711 (TTY).

We will add the information that You provide through testimony or other means to Your Claim file and We will review it without regard to whether this information was submitted and/or considered in Our initial decision regarding Your Claim.

Sharing Additional Information That We Collect

If We believe that Your Appeal of Our initial Adverse Benefit Determination will be denied, then before We issue Our next Adverse Benefit Determination We will also share with You any new or additional reasons for that decision. We will send You a letter explaining the new or additional information and/or reasons and inform You how You can respond to the information in the letter if You choose to do so. If You do not respond before We must make Our next decision, that decision will be based on the information already in Your Claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending Your Claim and Appeal to Us as described in this **APPEALS and COMPLAINTS** section:

1. Pre-Service Claims (Urgent and Non-Urgent)
2. Concurrent Care Claims (Urgent and Non-Urgent)
3. Post-Service Claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of coverage (rescission).

Your internal review process includes (a) one mandatory level of review which is the First Level Appeal and (b) a voluntary second level of review which is the Voluntary Second Level Appeal. The Voluntary Second Level Appeal may only occur at your option. If you disagree with our decision on your First Level Appeal, your adverse First Level Appeal decision notice will tell you how to submit a Voluntary Second Level Appeal.

When you file an appeal, We will review Your Claim without regard to our previous Adverse Benefit Determination. The individual who reviews Your Appeal will not have participated in Our original decision regarding Your Claim nor will he/she be the subordinate of someone who did participate in Our original decision.

1. Pre-Service Claims and Appeals
   Pre-service Claims are requests that We pay for a Service that You have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for Our denial of Your Pre-service Claim . If You receive any of the Services You are requesting before We make Our decision, Your Pre-service Claim or Appeal will become a Post-service Claim or Appeal with respect to those Services. If You have any general questions about Pre-service Claims or Appeals, please call **Customer Service** at 1-855-364-3184 or 711 (TTY).

   Here are the procedures for filing a Pre-service claim, a Non-urgent Pre-service Appeal, and an Urgent Pre-service Appeal.

   a. Pre-Service Claim
      Tell KPIC in writing that You want Us to pay for a Service You have not yet received. Your request and any related documents You give us constitute Your Claim. You or Your Provider must either mail or fax Your Claim to:

      Permanente Advantage
      5855 Copley Drive, Suite 250
      San Diego, CA 92111
      1-888-525-1533 (office)
      1-866-338-0266 (fax)

      If You want Us to consider Your Pre-service Claim on an Urgent basis, the request should tell us that. We will decide whether Your Claim is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Claim is Urgent. If We determine that Your Claim is not Urgent, We will treat Your Claim as Non-Urgent. Generally, a Claim is Urgent only if using the procedure for Non-Urgent Claims: (a) Could seriously jeopardize Your life, health, or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an Expedited External Review.

      Non-Urgent Pre-Service Claim
      We will review Your Claim and, if We have all the information We need, We will make a decision within a reasonable period of time but not later than five (5) business days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, so long as We notify You and inform You and Your Provider prior to the expiration of the initial five (5) day period and explain the circumstances for which we need the extension.

      If We need more information, We will ask You and Your Provider for additional information within the initial five (5) business day decision period, and We will give You and Your Provider two (2)

business days from receipt of Our request to send the additional information. We will make a decision within five (5) business days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive the additional information (including documents) from You or Your Provider within two (2) business days after receipt of Our request, We will make a decision based on the information We have.

We will send written notice of Our decision to You and Your Provider.

Urgent Pre-Service Claim

If Your Pre-service Claim was considered on an Urgent basis and We have all the information We need, We will notify You and Your Provider of Our decision (whether adverse or not) orally or in writing within two (2) business days but not later than seventy-two (72) hours after We receive Your Claim. Within twenty-four (24) hours after We receive Your Claim, We may ask You and Your Provider for more information. We will give You and Your Provider within two (2) business days from receipt of Our request to send the additional information. We will notify You and Your Provider of Our decision within two (2) business days but not longer than forty-eight (48) hours of receiving the first piece of requested information. If We do not receive the additional information (including documents) from You or Your Provider within two (2) business days after receipt of Our request, We will make a decision based on the information We have and We will notify You of Our decision either orally or in writing. If We notify You of Our decision orally, We will send You and Your Provider written confirmation within three (3) days after that.

Your Pre-Service Claim shall be deemed to have been approved for failure on Our part to:

a) Request additional information needed to process the claim from You and Your Provider; or
b) Provide the notification of approval to You and Your Provider; or
c) Provide the notification of denial to You and Your Provider

within the required time frames set forth above.

Validity of Approval of a Pre-Service Claim

An approval of a Pre-Service Claim is valid for a period of one hundred eighty (180) days after the date of approval and continues for the duration of the authorized course of treatment. Once approved, We cannot retroactively deny a Pre-certification request for a treatment or service. This 180-day approval does not apply if:

a) The Pre-Service Claim approval was based on Fraud; or
b) The provider never performed the services that were requested; or
c) The service provided did not align with the service that was approved; or
d) The person receiving the service no longer had coverage under the plan on or before the date the service was delivered; or
e) The covered person's benefit maximums were reached on or before the date the service was delivered.

If We deny Your Claim (if We do not agree to pay for all the Services You requested), Our Adverse Benefit Determination notice will tell You why We denied Your Claim and how You can appeal.

b. Non-Urgent Pre-Service First Level Appeal

Within one hundred eighty (180) days after You receive our Adverse Benefit Determination notice, You must tell us by either calling us or writing to us that You want to Appeal Our denial of Your Pre-service Claim. We will count the one hundred eighty (180) calendar starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that five (5) business day period.

Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) The specific service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal.

For medical benefits other than Outpatient Prescription Drugs, You must either mail or fax Your Appeal to the **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

For Outpatient Prescription Drugs, You can appeal orally by calling 1-800-788-2949 (Pharmacy Help Desk) or in writing by mailing to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal (who was not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that five-(5) day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than thirty (30) days after we receive Your Appeal.

If we deny Your Appeal, our Adverse Benefit Determination notice will tell you why we denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

c. Urgent Pre-Service First Level Appeal

Tell us that You want to urgently appeal our Adverse Benefit Determination regarding your Pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal.

For medical benefits other than Outpatient Prescription Drugs, You can appeal orally by calling **Customer Service** at 1-855-364-3184 or in writing by mailing or sending by fax to **Appeals Program** at.

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

For Outpatient Prescription Drugs, You can appeal orally by calling 1-800-788-2949 (Pharmacy Help Desk) or in writing by mailing to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131

When You send Your Appeal, You may also request simultaneous External Review of Our initial Adverse Benefit Determination. If You want simultaneous External Review, Your Appeal must tell Us this. You will be eligible for the simultaneous External Review only if Your Pre-service Appeal qualifies as Urgent. If You do not request simultaneous External Review in Your Appeal, then You may be able to request External Review after We make Our decision regarding Your Appeal (see "External Review" in this "**APPEALS and COMPLAINTS**" section), if Our internal Appeal decision is not in your favor.

We will decide whether Your Appeal is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Appeal is Urgent. If We determine that Your Appeal is not Urgent, We will treat Your Appeal as Non-Urgent. Generally, an Appeal is Urgent only if using the procedure for Non-Urgent Appeals (a) Could seriously jeopardize Your life, health, or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting. We may, but not required to waive the requirements related to an Urgent Appeal to permit you to pursue an Expedited External Review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review Your Appeal and give You oral or written notice of Our decision as soon as Your clinical condition requires, but not later than seventy-two (72) hours after We received Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

If We deny Your Appeal, our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

2. Concurrent Care Claims and Appeals.
Concurrent Care Claims are requests that KPIC continues to pay for an ongoing course of covered treatment or services for a period of time or number of treatments, when the course of treatment already being received will end. If You have any general questions about Concurrent Care Claims or Appeals, please call the **Customer Service** at 1-855-364-3184 or 711 (TTY).

Unless You are appealing an Urgent Concurrent Care Claim, if We either (a) Deny Your request to extend Your current authorized ongoing care (Your Concurrent Care Claim) or (b) Inform You that the authorized care that You are currently receiving is going to end early and You then appeal our decision (an Adverse Benefit Determination), then during the time that We are considering Your Appeal, You may continue to receive the authorized Services. If you continue to receive these Services while We consider Your Appeal and Your Appeal does not result in our approval of Your Concurrent Care Claim, then KPIC will only pay for the continuation of services until we notify you of our appeal decision.

Here are the procedures for filing a Concurrent Care Claim, a Non-Urgent Concurrent Care Appeal, and an Urgent Concurrent Care Appeal:

a. Concurrent Care Claim
Tell us by either calling us or writing to us that you want to make a Concurrent Care Claim for an ongoing course of covered treatment. Inform us in detail of the reasons that Your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute Your Claim. You must either mail or fax Your Claim to **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

If You want us to consider Your Claim on an Urgent basis and You contact us at least twenty-four (24) hours before Your care ends, You may request that We review Your Concurrent Claim on an Urgent basis. We will decide whether Your Claim is Urgent or Non-Urgent unless Your attending health care provider tells us Your Claim is Urgent. If We determine that Your Claim is not Urgent, We will treat Your Claim as Non-Urgent. Generally, a Claim is Urgent only if using the procedure for Non-Urgent Claims (a) Could seriously jeopardize Your life, health or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without extending Your course of covered treatment.. We may, but are not required to waive the requirements related to an Urgent appeal to permit you to pursue an expedited External Review.

We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim twenty-four (24) hours or more before Your care is ending, We will make our decision before Your authorized care actually ends (that is, within 24 hours of receipt of Your claim). If Your authorized care ended before You submitted Your Claim, We will make our decision within a reasonable period of time but no later than fifteen (15) days after we receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We send You notice before the initial fifteen-(15) day period ends and explain the circumstances and the reason for the extension and when we expect to make a decision.

If We tell You We need more information, We will ask You for the information before the initial decision period ends and We will give you until Your care is ending or, if Your care has ended, forty-five (45) days to send us the information. We will make our decision as soon as possible, if Your care has not ended, or within fifteen (15) days after We first receive any information (including documents) we requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate timeframe, not to exceed fifteen (15) days following the end of the forty-five (45) days that We gave you for sending the additional information.

We will send written notice of our decision to You and, if applicable to Your Provider, upon request. Please let Us know if You wish to have Our decision sent to Your Provider.

If We consider Your Concurrent Claim on an Urgent basis, We will notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than twenty-four (24) hours after We received Your Appeal. If We notify You of Our decision orally, We will send You written confirmation within three (3) days after receiving Your Claim.

If We deny Your Claim (if we do not agree to pay for extending the ongoing course of treatment or services), our Adverse Benefit Determination notice will tell you why We denied Your Claim and how You can appeal.

b. Non-Urgent Concurrent Care First Level Appeal

Within one hundred eighty (180) days after you receive our Adverse Benefit Determination notice, you must tell us by either calling us or writing to us that you want to appeal our Adverse Benefit Determination. We will count the one hundred eighty (180) calendar days starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The ongoing course of covered treatment that you want to continue or extend, (4) All of the reasons why you disagree with our Adverse Benefit Determination, and (5) All supporting documents. Your request and all supporting documents constitute Your Appeal. You must either mail or fax appeal to **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that five-day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send You a written decision as soon as possible if You care has not ended but not later than thirty (30) days after We receive Your Appeal.

If We deny Your Appeal, Our Adverse Benefit Determination decision will tell You why We denied Your Appeal and will include information about any further process, including External Review, that may be available to You.

c. Urgent Concurrent Care First Level Appeal

Tell us that You want to urgently appeal our Adverse Benefit Determination regarding Your urgent concurrent claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The ongoing course of covered treatment that You want to continue or extend, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal. You can appeal orally by calling Member Services or in writing by mailing or sending by fax to the **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

When You send Your Appeal, You may also request simultaneous External Review of Our Adverse Benefit Determination. If You want simultaneous External Review, Your Appeal must

tell Us this. You will be eligible for the simultaneous External Review only if Your Concurrent Care Claim qualifies as Urgent. If You do not request simultaneous External Review in Your Appeal, then You may be able to request External Review after We make Our decision regarding Your Appeal (see "External Review" in this **"APPEALS and COMPLAINTS"** section).

We will decide whether Your Appeal is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Appeal is Urgent. If We determine that Your Appeal is not Urgent, We will treat Your Appeal as Non-Urgent. Generally, an Appeal is Urgent only if using the procedure for Non-Urgent Appeals (a) Could seriously jeopardize Your life, health, or ability to regain maximum function: or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without continuing Your course of covered treatment,. We may, but not required to waive the requirements related to an Urgent appeal to permit you to pursue an Expedited External Review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written complaints, documents, record and other materials for the reviewer or reviewers to consider; and to receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review Your Appeal and notify You of Our decision orally or in writing as soon as Your clinical condition requires, but no later than seventy-two (72) hours after we receive Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information about any further process, including External Review, that may be available to You.

3. Post-Service Claims and Appeals

Post-service Claims are requests that We for pay for Services You already received, including Claims for Emergency Services rendered by Non-Participating Providers. If You have any general questions about Post-Service Claims or Appeals, please call **Customer Service** at 1-855-364-3184 or 711 (TTY).

Here are the procedures for filing a Post-service Claim and a Post-service Appeal:

a. Post-Service Claim

Within twelve (12) months from the date You received the Services, mail Us a letter explaining the Services for which You are requesting payment. Provide Us with the following: (1) The date You received the Services, (2) Where You received them, (3) Who provided them, and (4) Why You think We should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute Your Claim. Or, You may contact **Customer Service** at 1-855-364-3184 or 711 (TTY) to obtain a Claims form. You must mail Your Claim to **Claims Department** at:

National Claims Administration -Colorado
PO Box 373150
Denver, CO 80237-9998

We will not accept or pay for Claims received from You after twelve (12) months from the date of Services.

We will review Your Claim, and if We have all the information We need We will send You a written decision within thirty (30) days after We receive Your Claim. We may extend the time for making

a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We notify You within fifteen (15) days after We receive Your Claim and explain the circumstances and the reason for the extension and when we expect to make the decision.. If We tell You We need more information, We will ask You for the information and We will give you forty-five (45) days from the date of Your receipt of Our notice to send Us the information. We will make a decision within fifteen (15) days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within forty-five (45) days after We send Our request, We will make a decision based on the information We have within fifteen (15) days following the end of the forty-five (45) day period.

If We deny Your Claim (if We do not pay for all the Services You requested), Our Adverse Benefit Determination notice will tell You why We denied Your Claim and how You can appeal.

b. Post-Service First Level Appeal

Within one hundred eighty (180) days after You receive Our Adverse Benefit Determination, tell Us in writing that You want to appeal Our denial of Your Post-service Claim. We will count the one hundred eighty (180) calendar days starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The specific Services that You want Us to pay for, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) Include all supporting documents such as medical records. Your request and the supporting documents constitute Your Appeal. You must either mail or fax Your Appeal to:

Member Appeals Program
PO Box 378066
Denver, CO 80237
1-888-370-9858 (office)
1-866-466-4042 (fax)

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that 5-day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send You a written decision within thirty (30) days after We receive Your Appeal.

If We deny Your Appeal, Our Adverse Benefit Determination will tell You why We denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

Appeals of Retroactive Coverage Termination (Rescission or Retroactive Cancellation)

We may terminate your coverage retroactively (see Rescission for Fraud or Intentional Misrepresentation under **TERMINATION/NON-RENEWAL/CONTINUATION** section). We will send you written notice at least thirty (30) days prior to the termination. If you have general questions about retroactive coverage terminations or appeals, please call the **Customer Service** at 1-855-364-3184.

Here is the procedure for filing a First Level Appeal of a retroactive coverage termination:

Within one hundred eighty (180) days after you receive our Adverse Benefit Determination that your coverage will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your coverage retroactively. Please include the following: (1) Your name and Medical Record Number, (2) All of the reasons why you disagree with our retroactive membership termination, and (3) All supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 378066
Denver, CO 80237

We will review your appeal and send you a written decision within thirty (30) days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including External Review, that may be available to you.

Voluntary Second Level Appeal

A Voluntary Second Level Appeal is another review by Us that occurs after the mandatory internal Appeal decision is communicated to You if You remain dissatisfied with Our decision. This in-person review permits You to present evidence to the Second Level Appeal Panel and to ask questions**. Choosing a Voluntary Second Level Appeal will not affect Your right, if you have one, to request an independent External Review.**

Here is the procedure for a Voluntary Second Level of Appeal for medical benefits and Outpatient Prescription Drugs:

Within sixty (60) days from the date of Your receipt of Our notice regarding Your First Level of Appeal decision, we must receive your Voluntary Second Level Appeal requesting the review of the adverse decision. We will count the sixty (60) days starting five (5) business days from the date of the First Level of Appeal decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) The specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination (mandatory internal Appeal decision), and (5) All supporting documents. Your request and the supporting documents constitute Your request for a Voluntary Second Level of Appeal. You must either mail or fax Your Appeal to:

Kaiser Permanente Insurance Company (KPIC)
Grievance and Appeals Coordinator
1800 Harrison Street, 20th Floor
Oakland, CA 94612
1-877-727-9664 (fax)

Within sixty (60) calendar days following receipt of Your request, KPIC will hold a Voluntary Second Level Appeal meeting. KPIC shall notify You of the date on which the Voluntary Second Level Appeal Panel will meet at least twenty (20) days prior to the date of this in-person meeting. You have the right to request a postponement by calling **Membe**r **Appeals Program** at 1-888-370-9858 and your request cannot be unreasonably denied. You have the right to appear in person or by telephone conference at the review meeting. We will make our decision within seven (7) days of the completion of this meeting.

You may present Your Appeal in person before the Voluntary Second Level Appeal Panel, or request a file review. If You would like to present Your Appeal in person, but an in-person meeting is not practical, You may present Your Appeal by telephone by calling e **Member Appeals Program** at 1-888-370-9858. Please indicate in Your Appeal request how you want to present Your Appeal. Unless you request to be present for the special meeting in person or by telephone conference, we will conduct your appeal as a file review.

You may request in writing that KPIC transmit all material that will be presented to the Voluntary Second Level Appeal Panel at least five (5) days prior to the date of the Voluntary Second Level Appeal meeting.

You may submit additional information with Your Appeal request, or afterwards but no later than five (5) days prior to the date of Your Voluntary Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to Us as soon as practicable. You may present Your case to the Voluntary Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of Your choice including an attorney (at Your own expense), other advocate or health care professional. If You decide to have an attorney present at the Voluntary Second Level Appeal meeting, then You must let Us know that at least seven (7) days prior to that meeting. You must appoint this attorney as Your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If You would like further information about the Voluntary Second Level Appeal process, to assist You in making an informed decision about pursuing a Voluntary Second Level Appeal, please call **Member Appeals Program** at 1-888-370-9858. Your decision to pursue a Voluntary Second Level Appeal will have no effect on Your rights to any other benefits under this health insurance plan, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse First Level Appeal or Voluntary Second Level Appeal decision letter, You may have a right to request an External Review. There is no minimum dollar amount for a claim to be eligible for an External Review. You will not be responsible for the cost of the External Review.

You have the right to request an independent External Review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) A denial of a preauthorization for a Service; (2) A denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) A denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for External Review. However, independent External Review is available when we deny your appeal because you request medical care that is excluded under your plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

To request External Review, You must submit a completed Independent External Review of Carrier's Final Adverse Determination form (you may call **Member Appeals Program** at 1-888-370-9858 to request another copy of this form) which will be included with the mandatory internal appeal decision letter and explanation of Your Appeal rights, to **Member Appeals Program** within four (4) months of the date of receipt of Our mandatory First Level Appeal decision or of Our Voluntary Second Level Appeal decision. We shall consider the date of receipt for Our notice to be three (3) days after the date on which Our notice was postmarked ~~d~~, unless You can prove that You received our notice after the three (3)-day period ends.

You must include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Appeals Program** at 1-888-370-9858 to request a copy of this form)

If We do not receive Your External Review request form and/or authorization form to release your health information, then We will not be able to act on Your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for Your request of External Review.

Expedited External Review

You may request an Expedited External Review if (1) You have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize Your life, health, or ability to regain maximum function; or, (2) If You have a physical or mental existing disability that creates an imminent and substantial limitation to Your existing ability to live independently, or (3) In the opinion of a Physician with knowledge of Your medical condition, the timeframe for completion of a standard review would subject You to severe pain that cannot be adequately managed without the medical services that You are seeking.

You may request Expedited External Review simultaneously with your expedited internal appeal as permitted under this Plan. A request for an Expedited External Review must be accompanied by a written statement from Your Physician that Your condition meets the expedited criteria. You must include the Physician's certification that You meet External Review criteria when You submit Your request for External Review along with the other required information (described, above). No Expedited External Review is available when You have already received the medical care that is the subject of Your request for External Review. If You do not qualify for Expedited External Review, We will treat Your request as a request for Standard External Review.

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request External Review or expedited External Review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for External Review or expedited External Review must include a written statement from your physician that either (a) Standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b)There is no available standard health care service or treatment covered under this plan that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited External Review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for External Review.

After we receive your request for External Review, we shall notify you of the information regarding the independent External Review entity that the Division of Insurance has selected to conduct the External Review.

If We deny Your request for Standard or Expedited External Review, including any assertion that We have not complied with the applicable requirements related to Our Internal Claims and Appeals Procedure, then We may notify You in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that We send this denial notice to You, We will send a copy of it to the Division of Insurance.

You will not be able to present Your Appeal in person to the Independent External Review Organization. You may, however, send any additional information that is significantly different from information provided or considered during the Internal Claims and Appeal Procedure and, if applicable Voluntary Second Level of Appeal process. If You send new information, We may consider it and reverse our decision regarding Your Appeal.

You may submit Your additional information to the Independent External Review Organization for consideration during its review within five (5) working days of Your receipt of Our notice describing the Independent Review Organization that has been selected to conduct the External Review of Your Claim. Although it is not required to do so, the Independent Review Organization may accept and consider additional information submitted after this five (5) working day period ends.

The Independent External Review entity shall review information regarding Your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within forty (45) days of the Independent External Review entity's receipt of Your request for Standard External Review, it shall provide written notice of its decision to You. If the Independent External Review entity is deciding Your Expedited External Review request, then the Independent External Review entity shall make its decision as expeditiously as possible and no more than seventy-two (72) hours after its receipt of Your request for External Review and within forty-eight (48) hours of notifying You orally of its decision provide written confirmation of its decision. This notice shall explain that the External Review decision is the final appeal available under state insurance law. An External Review decision is binding on KPIC and You except to the extent KPIC and You have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for External Review involving the same adverse determination for which you have already received an External Review decision

If the Independent External Review Organization overturns Our denial of payment for care You have already received, We will issue payment within five (5) working days. If the Independent Review organization overturns Our decision not to authorize Pre-service or Concurrent Care Claims, KPIC will authorize care within one (1) working day. Such Covered Services shall be provided subject to the terms and conditions applicable to benefits under this health insurance plan.

Except when External Review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, You must exhaust Our Internal Claims and Appeals Procedure (but not the Voluntary Second Level of Appeal) for Your Claim before You may request External Review, unless We have failed to comply with federal and/or state law requirements regarding Our Claims and Appeals Procedures.

Additional Review

You may have certain additional rights if You remain dissatisfied after You have exhausted Our Internal Claims and Appeals Procedures, and if applicable, External Review. If You are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), You may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if Your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), You may have a right to request review in state court.

INFORMATION ON POLICY AND RATE CHANGES

Entire Contract and Changes
The Policyholder will act on behalf of all the Insured Employees in all matters pertaining to the Group Policy, and the following will be binding upon all Covered Persons: (1) every act done by the Policyholder; (2) every agreement between KPIC and the Policyholder; and (3) every notice given by either party to the other.

The entire contract between the Policyholder and KPIC consists of the Group Policy, certificates, amendments or riders incorporated by reference, the attached application of the Policyholder; and the applications, on file, if any, of the Insured Employees. All statements made by the Policyholder or Insured Employees will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or Insured Employees will be used in defense to a claim under the Group Policy, unless it is contained in a written application.

No change in the Group Policy will be valid unless:
1. It is noted on, or attached to, the Group Policy;
2. Signed by an executive officer of KPIC; and
3. Delivered to the Policyholder.

KPIC may change, cancel, or discontinue coverage, to the extent permitted by law, provided under the Group Policy without the consent of the Policyholder or Insured Employees. Payment of premium, after a change has been made and incorporated into the Group Policy, will be deemed acceptance of the changes made by KPIC. The Policyholder must mail or deliver notice of cancellation or discontinuance to all Insured Employees at least thirty-one (31) days prior to the date of cancellation or discontinuance of the Group Policy. Notice to the Insured Employee will be considered notice to any Insured Dependent of the Insured Employee.

No agent has the authority to:
1. Change the Group Policy;
2. Waive any provisions of the Group Policy;
3. Extend the time for payment of premiums; or
4. Waive any of KPIC's rights or requirements.

Premium Rates
KPIC may change any of the premium rates as of any Group Policy Anniversary, or at any other time by written agreement between the Policyholder and KPIC on any premium due date when:
1. The terms of the Group Policy are changed;
2. A division, a subsidiary or an affiliated company is added to the Group Policy; or
3. For reasons other than the above, such as, but not limited to, a change in factors bearing on the risk assumed. The rate may not be changed within the first six months following the Group Policy Effective Date.

KPIC will give the Policyholder thirty-one (31) days advance written notice of any change in premium.

KPIC will give the Policyholder a thirty-one (31) day grace period for the payment of any premium.

DEFINITIONS

The following terms have special meaning throughout this Certificate. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Certificate are defined in those sections.

"A" Recommendation means a recommendation adopted by the Task Force, which strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

Accumulation Period – The time period set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

ACIP means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the Federal Department of Health and Human Services, or any successor entity.

Administrator means Kaiser Foundation Health Plan of Colorado. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor its Administrator is the administrator of the Policyholder's employee benefit plan as that term is defined under Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA) as then constituted or later amended.

Applied Behavior Analysis means the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: (a) A federally funded or approved trial; (b) a clinical trial conducted under an FDA investigational new drug application; or (c) A drug that is exempt from the requirement of an FDA investigational new drug application.

Autism Services Provider means any person, who provides direct services to Covered Persons with Autism Spectrum Disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets one of the following:

1. Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one (1) year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
2. Has a doctoral degree in one of the behavioral or health sciences and has completed one (1) year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
3. Has a master's degree or higher in behavioral sciences and is nationally certified as a "Board Certified Behavior Analyst" or certified by a similar nationally recognized organization; or
4. Has a master's degree or higher in one (1) of the behavior or health sciences, is credentialed as a "Related Services Provider," and has completed one (1) year of direct supervised experience in behavioral therapies. Related Services Provider means physical therapist, an occupational therapist or speech therapist that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
5. Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a Board-Certified Associate Behavior Analyst or certified by a similarly recognized organization; or
6. Is nationally registered as a "registered behavior technician" by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with an autism spectrum disorder under the supervision of an autism services provider described in sub-subparagraph (1), (2), (3), (4), or (5) above.

DEFINITIONS

Autism Spectrum Disorders (ASD) means a disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis; and includes the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis: Autistic Disorder, Asperger's Disorder, and atypical Autism, as a diagnosis within pervasive developmental disorder, not otherwise specified.

Autism Treatment Plan means a plan developed for a Covered Person by an Autism Services Provider and prescribed by a Physician and licensed psychologist pursuant to comprehensive evaluation or reevaluation for a Covered Person consisting of the Covered Person's diagnosis, proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which by which the plan will be updated. The Treatment Plan shall be developed in accordance with patient-centered medical home, as defined under applicable Colorado law

"B" Recommendation means a recommendation adopted by the Task Force, which recommends that clinicians provide a preventive health care service because the Task Force found there is high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.

Behavioral Health, Mental Health and Substance Use Disorder:

1. Means a condition or disorder, regardless of etiology, that maybe the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the Mental Disorders section of the most recent version of:
   (a) The International Statistical Classification of Diseases and Health Related Problems;
   (b) The Diagnostic and Statistical Manual of Mental Disorders; or
   (c) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and
2. Includes Autism Spectrum Disorder.

Benefit Maximum means a maximum amount of benefits that will be paid by KPIC for a specified type of Covered Charges incurred during a given period of time. The charges to which a Benefit Maximum applies are not considered Covered Charges after the Benefit Maximum has been reached. Covered Charges in excess of the Benefit Maximum will not be applied toward satisfaction of the Accumulation Period Deductible and Out-of-Pocket Maximum. Benefit Maximum does not apply to Essential Health Benefits, as defined under this health insurance plan, received at either the Participating Provider level or the Non-Participating level.

Birth Center means an outpatient facility which:

1. Complies with licensing and other legal requirements in the jurisdiction where it is located;
2. Is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal to low risk patients;
3. Has organized facilities for Birth Services on its premises;
4. Has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a Licensed Midwife or Certified Nurse Midwife; and
5. Has 24-hour-a-day Registered Nurse services.

Birth Services means ante partum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: (1) uncomplicated pregnancy and labor; and (2) spontaneous vaginal delivery.

Benefits payable for the treatment of complications of pregnancy will be covered on the same basis as any other Sickness.

Calendar Year means a period of time: (1) beginning at 12:01 a.m. on January 1st of any year; and (2) terminating at midnight on December 31st of that same year.

Certified Nurse-Midwife or Licensed Midwife means any person duly certified or licensed as such in the state in which treatment is received and is acting within the scope of his or her license at the time

the treatment is performed.

Certified Nurse Practitioner means a Registered Nurse duly licensed in the state in which the treatment is received who has completed a formal educational nurse practitioner program. He or she must be certified as such by the: (1) American Nurses' Association; (2) National Board of Pediatric Nurse Practitioners and Associates; or (3) Nurses' Association of the American College of Obstetricians and Gynecologists.

Certified Psychiatric-Mental Health Clinical Nurse Specialist means any Registered Nurse licensed in the state in which the treatment is received who: (1) has completed a formal educational program as a psychiatric-mental health clinical nurse specialist; and (2) is certified by the American Nurses' Association.

Child Health Supervision Services means those preventive services and immunizations required to be provided in a Colorado basic and standard health benefit plan in accordance with Colorado Code Section 10-16-105 (7.2), as then constituted and later amended to covered Dependent children up through age twelve (12). Services must be provided by a Physician or pursuant to a physician's supervision or by a primary health care provider who is a Physician's assistant or Registered Nurse who has additional training in child health assessment and who is working in collaboration with a Physician.

Clean Claim means a claim for payment of health care expenses that is submitted to KPIC or its administrator on its standard claim form with all required fields completed with correct and complete information in accordance with KPIC's published filing requirements. A Clean Claim does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

Clinical Social Worker means a person who is licensed as a clinical social worker, and who has at least five years of experience in psychotherapy (as defined by the state of Colorado) under appropriate supervision, beyond a master's degree.

Clinical Trial means an experiment, in which a drug or device is administered to dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs, as well as the use of drug in combination with alternative therapy or dietary supplement.

Coinsurance means a percentage of charges that You must pay as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section when You receive a Covered Service as described under the **BENEFITS/COVERAGE (What is Covered)** section and the Policy Schedule. Coinsurance amount is applied against the Covered Charge.

Complications of Pregnancy means (1) conditions when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; (2) Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include conditions such as false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Complications of Pregnancy are covered under this Certificate as any other Sickness or Injury.

DEFINITIONS

Comprehensive Rehabilitation Facility means a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled individuals. The facility must be accredited for the provision of these services by the Commission on Accreditation of Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

Confinement means physically occupying a room and being charged for room and board in a Hospital or other covered facility on a twenty-four hour a day basis as a registered inpatient upon the order of a Physician.

Copayment means the predetermined amount, as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section, which is to be paid by the Insured for a Covered Service, usually at the time the health care is rendered. All Copayments applicable to the Covered Services are shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Cosmetic Surgery means surgery that: (a) is performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance; and (b) will not result in significant improvement in physical function. Cosmetic Surgery is not covered under this Policy.

Cost Share means a Covered Person's share of Covered Charges. Cost Share includes and is limited only to the following: 1) Coinsurance; 2) Copayment; 3) per benefit deductibles; and 4) Deductible.

Covered Charge or Covered Charges means the Maximum Allowable Charge(s) for a Covered Service.

Covered Person means a person covered under the terms of the Group Policy. A Covered Person who is enrolled as an Insured Employee or Insured Dependent under the Plan. Also, sometimes referred to as member. No person may be covered as both an Insured Employee and a Dependent at the same time under a single Group Policy.

Covered Services means those services which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section entitled **BENEFITS/COVERAGE (What is Covered).**

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during that Accumulation Period. The Deductible will apply to each Covered Person separately, and must be met within each Accumulation Period. When Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person.

Some Covered Services are subject to additional or separate deductible amounts as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. These additional or separate deductibles are neither subject to, nor do they contribute towards the satisfaction of the Self-Only Deductible or Individual Deductible or the Family Deductible Maximum.

Dependent means:

1. Your lawful spouse, partner in a civil union or Domestic Partner (if Domestic Partner is covered under this plan); or
2. Your or Your spouse's, Your partner in a civil union or Your Domestic Partner natural or adopted or foster child, if that child is under age of 26.
3. Other unmarried dependent person who meet all of the following requirements:
   a. Is under the dependent limiting age specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section; and
   b. You or Your Spouse, Your partner in a civil union or Your Domestic Partner is the court-appointed permanent legal guardian or was before the person reached age 18.
4. Your or Your Spouse's Your partner in a civil union, Your Domestic Partner unmarried child of any age; who is medically certified as disabled and dependent upon You, Your Spouse, Your partner in

a civil union or Your Domestic Partner, are eligible to enroll or continue coverage as Your Dependents if the following requirements are met:

a. They are dependent on You or Your Spouse, Your partner in a civil union or Your Domestic Partner; and
b. You give us proof of the Dependent's disability and dependency annually if We request it.

Detoxification means the process of removing toxic substances from the body.

Domestic Partner means an unmarried adult who resides with the Insured Employee for at least six (6) months in a committed relationship. A Domestic Partner may be regarded as a Dependent, upon meeting Our prescribed requirements, which include the following:

1. Both persons must have a common residence for a period of at least six months prior to eligibility for this coverage;
2. Both persons must agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
3. Neither person is married nor a member of another domestic partnership or have been a party to a domestic partnership that was terminated within twelve (12) months before becoming eligible for this coverage;
4. The two persons are not related by blood in a way that would prevent them from being married to each other in conformity with state law;
5. Both persons must be at least 18 years of age and be the same sex;
6. Both persons must be capable of consenting to the domestic partnership;
7. Neither person is legally married to or legally separated from another person; and
8. Both persons must have duly executed a declaration of domestic partnership on a form agreed to by Us.

Durable Medical Equipment means equipment which:

1. Is designed for repeated use;
2. Can mainly and customarily be used for medical purposes;
3. Is not generally of use to a person in the absence of a Sickness or Injury;
4. Is approved for coverage under Medicare, including insulin pumps and insulin pump supplies;
5. Is not primarily or customarily for the convenience of the Covered Person;
6. Provides direct aid or relief of the Covered Person's medical condition;
7. Is Appropriate for use in the home;
8. Serves a specific therapeutic purpose in the treatment of an illness or injury; and
9. Is an infant apnea monitor.

Durable Medical Equipment does not include:

1. Oxygen tents;
2. Equipment generally used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, bathtub lifts, adjust-a-beds, telephone arms, air conditioners, and humidifiers);
3. Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Covered Person's condition and in order for the Covered Person to operate the equipment;
4. Disposable supplies, exercise and hygiene equipment, experimental or research equipment, and devices not medical in nature such as sauna baths, elevators, or modifications to the home or automobile. This exclusion does not apply to disposable diabetic supplies;
5. Devices for testing blood or other body substances, except diabetic testing equipment and supplies;
6. Electronic monitors of bodily functions, except infant apnea monitors;
7. Replacement of lost equipment;
8. Repair, adjustments, or replacements necessitated by misuse;
9. More than one piece of Durable Medical Equipment serving essentially the same function; except for replacements other than those necessitated by misuse or loss; and
10. Spare or alternate use equipment.

Early Childhood Intervention Services means services as defined by the Colorado Department of Human Services in accordance with Part C of the Individuals with Disabilities Education Act of 2004,

as then constituted and later amended, that are authorized through an Insured Dependent's Individualized Family Service Plan, but excluding non-emergency medical transportation; respite care; service coordination, as defined under applicable federal regulation; and assistive technology.

Eligible Employee means a person who, at the time of original enrollment: (a) is working for a Policyholder as a full-time employee as described below or is entitled to coverage under an employment contract; (b) by virtue of such employment or contract enrolls under the Group Policy and (c) reached an eligibility date. Eligible Employee includes sole proprietors, partners of a partnership, or independent contractor if they are included as employees under a health benefit plan of the Policyholder, engaged on a full-time basis in the employer's business or are entitled to coverage under an employment contract. The term Eligible Employee does not include employees who work on a temporary seasonal or substitute basis.

Eligible Insured Dependent means an infant or toddler, from birth up to the child's third birthday, who has significant delays in development or has a diagnosed physical or mental condition that has high probability or resulting in significant delays in development or who is applicable is eligible for Early Childhood Intervention Services pursuant to applicable Colorado law. Please refer to the definition of Insured Dependent.

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

1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

Emergency Medical Condition: A medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Essential Health Benefits means the general categories of benefits including the items and services covered within these categories of benefits that comprise an essential health benefit package as defined under the Patient Protection and Affordable Care Act of 2010 (PPACA) as then constituted or later amended.

Expense(s) Incurred means expenses a Covered Person incurs for Covered Services. An expense is deemed incurred as of the date of the service, treatment, or purchase.

Formulary means a list of prescription drugs we cover.

Free-Standing Surgical Facility means a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:

1. Has permanent operating rooms;
2. Has at least one recovery room;
3. Has all necessary equipment for use before, during and after surgery;
4. Is supervised by an organized medical staff, including Registered Nurses available for care in an operating or recovery room;
5. Has a contract with at least one nearby Hospital for immediate acceptance of patients requiring

Hospital care following care in the Free-Standing Surgical Facility;
6. Is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. Requires that admission and discharge take place within the same working day.

Group Policy means the health insurance contract issued by KPIC to the Policyholder that establishes the rights and obligations of KPIC and the Policyholder.

Habilitative Services means services and devices that help a person retain, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of outpatient settings.

Health Plan means Kaiser Foundation Health Plan of Colorado.

Home Health Agency means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies and is engaged in arranging and providing nursing services, Home Health Services, and other therapeutic and related services.

Home Health Visit is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to four hours by a home health aide shall be considered as one visit

Homemaker Services means services provided to a Covered Person for Hospice Care which include:
1. General household activities including the preparation of meals and routine household care; and
2. Teaching, demonstrating and providing the Covered Person or their family with household management techniques that promote self-care, independent living and good nutrition.

Hospice Care means home-based palliative and supportive care by a licensed hospice for terminally ill patients. The care must be provided: (1) directly; or (2) on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For Hospice Care, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 months.

Hospital means an institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:
1. Is legally operated as a Hospital in the jurisdiction where it is located;
2. Is engaged mainly in providing inpatient medical care and treatment for Injury and Sickness in return for compensation;
3. Has organized facilities for diagnosis and major surgery on its premises;
4. Is supervised by a staff of at least two Physicians;
5. Has 24-hour-a-day nursing service by Registered Nurses; and
6. Is not: a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; or a Skilled Nursing Facility or similar institution.

The term **Hospital** will also include a psychiatric health facility which is currently licensed or certified by the Colorado Department of Public Health and Environment pursuant to the Department's authority under applicable Colorado law.

Hospital Confinement means being registered as an inpatient in a Hospital upon the order of a Physician.

Individualized Education Plan means a written plan for an Insured Dependent with a disability that is developed, reviewed, and revised in accordance with Colorado's applicable statutory and regulatory standards.

Individualized Family Service Plan is a written plan developed pursuant of to applicable federal statutory and regulatory standards, which authorizes the provision of Early Childhood Intervention Services to an Eligible Insured Dependent and to his or her family.

Individualized Plan means a written plan designed by an interdisciplinary team for the purpose of identifying the following: (a) needs of the Covered Person or family receiving the services; (b) the specific services and supports appropriate to meet such needs; (c) the projected date of initiation of services and supports; and (d) the anticipated results to be achieved by receiving the services and supports.

Injury means accidental bodily Injury of a Covered Person.

Insured Dependent means a Covered Person who is a Dependent of an Insured Employee.

Insured Employee means a Covered Person who is an Eligible Employee of the Policyholder or is one entitled to coverage under a welfare trust agreement.

Intensive Care Unit means a section, ward or wing within the Hospital which:
1. Is separated from other Hospital facilities;
2. Is operated exclusively for the purpose of providing professional care and treatment for critically-ill patients;
3. Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. Provides Room and Board; and
5. Provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Interdisciplinary Team means a group of qualified individuals, which includes, but is not limited to, a Physician, Registered Nurse, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice patients and their families.

Intractable Pain means a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

Licensed Vocational Nurse (LVN) means an individual who has (1) specialized nursing training; (2) vocational nursing experience; and (3) is duly licensed to perform nursing service by the state in which he or she performs such service.

Maximum Allowable Charge means:
1. For Covered Services from Participating Providers, the Negotiated Rate as defined under Paragraph 4 (b).
2. For Covered Services from Non-Participating Providers rendering the following services in the state of Colorado:
   (a) Emergency or Non-Emergency Services rendered in Participating facilities by physicians and other professionals that are Non-Participating Providers:
   (b) Emergency Services rendered in a non-Denver Health Hospital Authority operated Non-Participating facility.
   (c) Emergency Services rendered in a Denver Health Hospital Authority operated Non-Participating Provider facility.

   the reimbursement rate according to state law.

   Other than applicable cost sharing (Deductible, Coinsurance or Copayments) Non-Participating Providers rendering services in the state of Colorado may not balance bill a Covered Person for the

difference between the Maximum Allowable Charge and the Actual Billed Charges. However, a Non-Participating Provider may balance bill a Covered Person when the Covered Person chooses to use the Non-Participating Provider.

3. For Emergency Services rendered by Non-Participating Providers outside the state of Colorado, the following rules apply:

   If the amount payable by KPIC is less than the Actual Billed Charges by Non-Participating Providers for Emergency Service, KPIC will pay no less than the greatest of the following:
   (a) The Negotiated Rate for the service. If there is more than one Negotiated Rate with a Participating Provider for a particular service, then such amount is the median of these Negotiated Rate, treating the Negotiated Rate with each provider as a separate Negotiated Rate, and using an average of the middle two Negotiated Rates if there is an even number of Negotiated Rates.
   (b) The amount it would pay for the service if it used the same method (for example, Usual and Customary charges) that it generally uses to determine payments for services rendered by Non- Participating Providers and if there were no Cost Share (for example, if it generally pays 80% of UCR and the Cost Share is 20%, this amount would be 100% of UCR).
   (c) The amount that Medicare (Part A or B) would pay for the service.

4. For all other Covered Services from a Non-Participating Provider, the lesser of:
   (a) The Usual, Customary and Reasonable Charge (UCR):
   The Usual, Customary & Reasonable (UCR) Charge is the lesser of: or
      (i) The charge generally made by a Physician or other supplier of services, medicines, or supplies;
      (ii) The general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

   The term "area" as it would apply to any particular service, medicine or supply means a city or such greater area as is necessary to obtain a representative cross section of level of charges.

   If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to the Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges. Such difference will not apply towards satisfaction of the Out-of-Pocket Maximum nor any Deductible under the Group Policy.

   (b) The Negotiated Rate:
   KPIC or its authorized Administrator may have a contractual arrangement with the provider or supplier of Covered Services under which discounts have been negotiated for certain services or supplies. Any such discount is referred to as the Negotiated Rate.

   If there is a Negotiated Rate, the provider will accept the Negotiated Rate as payment in full for Covered Services, subject to the payment of Deductibles and coinsurance by the Covered Person.

   (c) The Actual Billed Charges for the Covered Services:
   The charges billed by the provider for Covered Services.

IMPORTANT: Notwithstanding the foregoing, the Maximum Allowable Charge for a Hospital or other licensed medical facility confinement may not exceed:

Hospital Routine Care Daily Limit:	the Hospital's average semi-private room rate
Intensive Care Daily Limit:	the Hospital's average Intensive Care Unit room rate
Other licensed medical facility Daily Limit:	the facility's average semi-private room rate

Maximum Benefit While Insured means the dollar limitation of Covered Charges as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section that will be paid for a Covered Person, while covered under the Group Policy. Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured at the Participating Provider level.

Medical Foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via a tube or oral route under the direction of Participating Physician. This definition shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

Medically Necessary means services that, in the judgment of KPIC, are:
1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility;
6. Not primarily custodial care;
7. Not experimental or investigational; and
8. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

Medically Necessary Leave of Absence or Medical Leave of Absence means a leave of absence from a post-secondary educational institution or a change in enrollment of the dependent at the institution that: (a) begins while the Dependent is suffering from a serious illness; (b) is medically necessary, and (c) causes the Dependent to lose student status for the purpose of Dependent coverage

Medical Review Program means the organization or program that (1) evaluates proposed treatments and/or services to determinate Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours a day, seven (7) days a week.

Medical Social Services means those services provided by an individual who possesses a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience. Such services are provided at the recommendation of a Physician for the purpose of assisting a Covered Person or the family in dealing with a specific medical condition.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Mental Health-- Please refer to the definition of **Behavioral Health, Mental Health and Substance Use Disorder** above**.**

DEFINITIONS

Month means a period of time: (1) beginning with the date stated in the Group Policy; and (2) terminating on the same date of the succeeding calendar month. If the succeeding calendar month has no such date, the last day of the month will be used.

Necessary Services and Supplies means Medically Necessary Covered Services and supplies actually administered during any covered confinement or administered during other covered treatment. Only drugs and materials that require supervision or administration by medical personnel during a covered confinement or other covered treatment are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to, surgically implanted prosthetic devices, F, blood, blood products, and biological sera. The term does not include charges for: (1) Room and Board; (2) an Intensive Care Unit; or (3) the services of a private duty nurse, Physician, or other practitioner.

Negotiated Rate means the fees KPIC has negotiated with a Provider to accept as payment in full for Covered Services rendered to Covered Persons.

Non-Participating Pharmacy means a pharmacy that does not have a Participating Pharmacy agreement with KPIC or its administrator in effect at the time services are rendered. Please consult with Your group administrator for a list of Participating Pharmacies.

Non-Participating Provider means a Hospital, Physician or other duly licensed health care provider or facility that does not have a participation agreement with KPIC or KPIC's Provider network in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your bill when You visit a Non-Participating Provider. Participating Providers are listed in the Participating Provider directory.

Open Enrollment Period means a fixed period of time, occurring at least once annually, during which Eligible Employees of the Policyholder may elect to enroll under this health insurance plan without incurring the status of being a Late Enrollee.

Orthotics means rigid or semi rigid external devices which: a) support or correct a defective form or function of an inoperative or malfunctioning body part; or b) restrict motion in a diseased or injured part of the body. Orthotics do not include casts.

Out-of-Pocket means the Cost Share incurred by a Covered Person.

Out-of-Pocket Maximum means the maximum amount of Cost Share a Covered Person will be responsible for in an Accumulation Period.

Palliative Services means those services and/or interventions which produce the greatest degree of relief from the symptoms of a terminal Sickness.

Partial Hospitalization means continuous treatment for at least three (3) hours, but not more than twelve (12) hours, in any 24-hour period.

Participating Pharmacy means a pharmacy which has a Participating Pharmacy agreement in effect with KPIC at the time services are rendered. Please consult with Your group administrator for a list of Participating Pharmacies.

Participating Provider means a health care provider duly licensed in the state in which such provider is practicing, including a Primary Care Physician, Specialty Care Physician, Hospital, Participating Pharmacy, laboratory, other similar entity under a written contract with a Preferred Provider Organization (PPO), KPIC or its Administrator. Please consult with Your group administrator for a list of Participating Providers.

Patient Protection and Affordable Care Act (PPACA) – means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended.

DEFINITIONS

Percentage Payable means that percentage of Covered Charges to be paid by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services.

Physician means a practitioner who is duly licensed as a Physician in the state in which the treatment is received. He or she must be practicing within the scope of that license. The term does not include a practitioner who is defined elsewhere in this **DEFINITIONS** section.

Placement for Adoption means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates.

Plan/This health insurance plan means the part of the Group Policy that provides benefits for health care expenses. If "Plan" has a different meaning for another section of this Certificate, the term will be defined within that section and that meaning will supersede this definition only or that section.

Policyholder means the employer(s) or trust(s) or other entity noted in the Group Policy as the Policyholder who conforms to the administrative and other provisions established under the Group Policy.

Policy Year means a period of time: (1) beginning with this health insurance plan Effective Date of any year; and (2) terminating, unless otherwise noted on the Group Policy, on the same date shown on the **SCHEDULE OF BENEFITS (Who Pays What)** section. If this health insurance plan Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

Pre-certification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment other than outpatient prescription drugs, made by the Medical Review Program. Consistent with applicable Colorado law, the sole responsibility for obtaining any necessary Pre-certification rests with the Participating Provider, who recommends or orders Covered Services, and not with the Covered Person.

Pre-certification will not result in payment of benefits that would not otherwise be covered under the Group Policy.

Preferred Brand Name Prescription Drug means a prescription drug that has been patented and is only produced by one manufacturer and is listed in Our Preferred Drug List of preferred prescribed medication.

Preferred Drug List is a listing of preferred prescribed medications that are covered under Your group coverage. Such listing is subject to change on a quarterly basis. Any product, which is not indicated in the listing or in updates thereof, will be considered a non-preferred medication. You may request a copy of the **Preferred Drug List,** Our Formulary, by calling toll-free at (800) 788-2949 (Pharmacy Help Desk), Monday through Friday.

Preferred Generic Prescription Drug means a prescription drug which does not bear the trademark of a specific manufacturer. Such drug is also listed in Our drug formulary of preferred prescribed medication.

Preferred Provider Organization (PPO) means a KPIC plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred or Participating Providers. Generally, a higher level of benefits applies to Covered Services received from preferred or Participating Providers and facilities. The **SCHEDULE OF BENEFITS (Who Pays What)** section shows the plan type under which the Covered Person is insured.

Pregnancy means the physical condition of being pregnant, but does not include Complications of Pregnancy.

Preventive Care means measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

1) protects against disease such as in the use of immunizations,

2) promotes health, such as counseling on tobacco use, and
3) detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

Unless otherwise specified, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to Preventive Care.

Primary Care Physician/Provider means a Physician or other licensed provider specializing in internal medicine, family practice, general practice, internal medicine, and pediatrics.

Prosthetic Devices (External) means a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Examples of external prosthetics includes artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eyeware after cataract surgery or eyeware to correct aphakia. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.

Prosthetic Devices (Internally implanted) means a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover internally implanted prosthetic devices that replace the function of all or part of an internal body organ, including internally implanted breast prostheses following a covered mastectomy. The devices must be approved for coverage under Medicare and for general use by the Food and Drug Administration (FDA). Examples of internally implanted prosthetics include pacemakers, surgically implanted artificial hips and knees and intraocular lenses.

Psychiatric Care means direct or consultative services provided by a psychiatrist, who is duly licensed by the State Board of Medical Examiner in accordance with applicable Colorado law.

Psychological Care means direct or consultative services provided by a psychologist, who is licensed by the State Board of Psychologist Examiners pursuant to applicable e Colorado law or a social worker, who is licensed by the State Board of Social Work Examiners pursuant to applicable Colorado law.

Reconstructive Surgery means a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance to the extent possible.

Registered Nurse (RN) means a duly licensed nurse acting within the scope of his or her license at the time the treatment or service is performed in the state in which services are provided.

Rehabilitation means services and devices provided to restore previously existing physical function which has been lost as a result of illness or injury when a physician determines that therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

Residential Treatment means Medically Necessary services provided in a licensed residential treatment facility that provides 24-hour individualized Substance Use Disorder or Mental Health treatment. Services must be above the level of custodial care and include:

1. room and board;
2. individual and group Substance Use Disorder therapy and counseling;
3. individual and group mental health therapy and counseling;
4. physician services;
5. medication monitoring;
6. social services; and
7. drugs prescribed by a physician and administered during confinement in the residential facility.

Room and Board means all charges commonly made by a Hospital or other inpatient medical facility on its own behalf for room and meals essential to the care of registered bed patients.

Routine Patient Care Costs means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an Approved Clinical Trial program, including the following:

1. Health care services typically provided absent a clinical trial.
2. Health care services required solely for the provision of the investigational drug, item, device, or service.
3. Health care services required for the clinically appropriate monitoring of the investigational item or service.
4. Health care services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service.
5. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine Patient Care Costs do not include the costs associated with the provision of any of the following:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Covered Person may require as a result of the treatment being provided for purposes of the clinical trial.
3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
4. Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy.
5. Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Sickness means an illness or a disease of a Covered Person. Sickness will include congenital defects or birth abnormalities.

Skilled Nursing Facility means an institution (or a distinct part of an institution) which:

1. provides 24-hour-a-day licensed nursing care;
2. has in effect a transfer agreement with one or more Hospitals;
3. is primarily engaged in providing skilled nursing care as part of an ongoing therapeutic regimen; and
4. is licensed under applicable state law.

Specialty Care Physician/Provider means a Physician or other licensed provider whose practice is limited to a certain branch of medicine, which includes non-standard medical-surgical services because of the specialized knowledge required for service delivery and management. Such services may include consultations with Physicians other than Primary Care Physicians in departments other than those listed under the definition of Primary Care Physician.

Specialty Care Visits means consultations with Specialty Care Physicians.

Specialty Drugs means prescribed medications such as self-injectable medications, as listed in Our Drug Preferred List. The level of coverage of Specialty Drugs is set forth in Your **SCHEDULE OF BENEFITS (Who Pays What)** section.

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

DEFINITIONS

Substance Use Disorder– Please refer to the definition of **Behavioral Health, Mental Health and Substance Use Disorder** above.

Task Force means the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services

Telehealth means a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Covered Person's health care while the Covered Person is located at an originating site and the provider is located at a distant site. Remote monitoring means the use of synchronous or asynchronous technologies to collect or monitor medical and other forms of health data for individuals at an originating site and electronically that transmit that information to providers at a distant site so providers can assess, diagnose, consult, treat, educate, provide care management, suggest self-management, or make recommendations regarding a Covered Person's health care.

Terminally Ill means that a Covered Person's life expectancy, as determined by a Physician, is not greater than six months.

Urgent Care means non-life threatening medical and health services. Urgent Care services may be covered under the Group Policy the same as a Sickness or an Injury.

Urgent Care Center means a facility that meets all of the tests that follow:

1. It mainly provides urgent or emergency medical treatment for acute conditions;
2. It does not provide services or accommodations for overnight stays;
3. It is open to receive patients each day of a calendar year;
4. It has on duty at all times a Physician trained in emergency medicine and nurses and other supporting personnel who are specially trained in emergency care;
5. It has: x-ray and laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening events;
6. It has a written agreement with a local acute care hospital for the immediate transfer of patients who require greater care than can be furnished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care hospital that are immediate and reliable;
7. It complies with all licensing and other legal requirements.

Well-child Care Services means those preventive services and immunization services as set forth in the **BENEFITS/COVERAGE (What is Covered)** section of this Certificate. Services must be provided by a Physician or pursuant to Physician's supervision or by a primary health care provider who is a Physician's assistant or Registered Nurse, who has additional training in child health assessment and who is working in collaboration with a Physician.

Well-child Visit means a visit to a primary care provider that includes the following elements:

1. Age appropriate physical exam, but not a complete exam, unless the exam is age appropriate;
2. History;
3. Anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behavior, etc.);
4. Growth and development assessment, which also includes safety and health education counseling for other children.

You/Your refers to the Insured Employee who is enrolled for benefits under this health insurance plan**.**

Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from ”surprise billing”. This is sometimes called “balance billing” and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a “CO-DOI” on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan’s network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as “out-of-network”.

Out-of-network hospitals, facilities or providers often bill you the difference between what Kaiser Permanente Insurance Company (KPIC) decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called ‘surprise’ or ‘balance’ billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- KPIC will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- KPIC will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you do receive a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at 303-894-7490 or 1-800-9303745.

Ambulance Information: You may be balance billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by KPIC, you may receive a balance bill.

Kaiser Permanente Insurance Company One
Kaiser Plaza
Oakland, CA 94612
KPIC-GC-PPO-LG-2021-CO-NGF

Additional Information and Forms Applicable to Your Insurance Coverage

Please note the following pages are not part of the employer group insurance policy.

The following pages contain information we are required to provide you.

KAISER PERMANENTE
KAISER PERMANENTE INSURANCE COMPANY

PRIVACY NOTICE

Privacy Policy and Practices

This notice describes the privacy policy and practices regarding non-public personal information followed by Kaiser Permanente Insurance Company (herein referred to as "KPIC', "we", "us", and "our"). This notice is provided to you in compliance with the Gramm-Leach-Bliley Financial Services Modernization Act.

Collection of Non-public Personal Information

The types of non-public personal information that we may collect includes, but are not limited to:

- Information we receive from you as part of application forms, enrollment forms, claims forms, pre-certification/utilization reviews, etc, including, but not limited to, your name, address, sex, date of birth, Social Security number, martial status, dependents, and the identity of your employer.
- Information otherwise legally obtained by us, including information you authorize us to receive and/or resulting from your transactions with us, our affiliates, or non-affiliated third parties, including, but not limited to, medical information and claims history.

Disclosure of Non-public Personal Information

Unless otherwise authorized by you, KPIC will not disclose your non-public personal information except to affiliates and non-affiliates third parties as necessary to administer, underwrite, process, service, reinsure or market its own insurance products, or as necessary to effect, administer, or enforce a transaction authorized by you. When KPIC must release non-public personal information to non-affiliated third parties, as noted above, such third parties will subject to contractual agreements that require the third parties to maintain the confidentiality of such non-public personal information. If, at a future date, KPIC determines there is a need to share your non-public personal information with a non-affiliated third party, other than as described above, we will provide you with an advance opportunity to direct us not share such information.

KPIC may also disclose non-public personal information to authorized persons or entities to comply with: federal, state, or local laws, including any properly authorized civil, criminal, or regulatory investigation or subpoena or summons; or respond to judicial process or government regulatory authorities having jurisdiction over us for examination, compliance, or other purposes as authorized by law.

Non-public Personal Information Regarding Former Customers

Any non-public personal information KPIC maintains on former customers will be maintained on a confidential and secure basis. Any discosure of that information will only be made in keeping with the privacy policy and practices described in this notice or as otherwise permitted or required by law.

Confidentiality and Security of Non-public Personal Information

KPIC is committed to protecting the confidentiality and security of non-public personal information. In collaboration with our affiliates, we maintain physical, electronic, and procedural safeguards that comply with federal and state standards regarding the protection of such information. To insure that your information is not misused and is properly protected, KPIC has instituted the following:

- Employees are required to comply with our policies and procedures that exist to protect the confidentiality of customer information. Any employee who violates our privacy policy and practices is subject to a disciplinary process. Our policy requires medical records to be maintained in secure areas not accessible to the public.
- Employee access to information is provided on a business need-to-know basis such as: to facilitate administration, make benefit determinations, pay claims, managed care, underwrite coverage, or provide customer service.
- Mail and electronic security procedures to maintain confidentiality of the information we collect and to guard against its unauthorized access. Such methods include locked files, user authentication, encryption, and firewall technology.
- Contractual agreements with its non-affiliated third parties that require such third parties to maintain the confidentiality of non-public personal information.

Where to Write For More Information

If you have any questions about KPIC's privacy policy and practices, please write to the address listed below:

Kaiser Permanente Insurance Company
Attention: President
One Kaiser Plaza, 25 B
Oakland, California 94612

HIPAA Notice of Privacy Practices

KAISER PERMANENTE INSURANCE COMPANY ("KPIC")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this Notice we use the terms "we," "us" and "our" to describe KPIC.

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

Your protected health information ("PHI") is individually identifiable health information, including demographic information, about your past, present or future physical or mental health or condition, health care services you receive, and past, present or future payment for your health care. Demographic information means information such as your name, social security number, address, and date of birth.

PHI may be in oral, written or electronic form. Examples of PHI include your medical record, claims record, enrollment or disenrollment information, and communications between you and your health care provider about your care.

With the exception of those insured in California, your individually identifiable health information ceases to be PHI 50 years after your death.

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

1. protect the privacy of your PHI;
2. tell you about your rights and our legal duties with respect to your PHI;
3. notify you if there is a breach of your unsecured PHI; and
4. tell you about our privacy practices and follow our Notice currently in effect.

We take these responsibilities seriously, and have put in place administrative safeguards (such as security awareness training and policies and procedures), technical safeguards (such as encryption and passwords), and physical safeguards (such as locked areas and requiring badges) to protect your PHI and, as in the past, we will continue to take appropriate steps to safeguard the privacy of your PHI.

III. YOUR RIGHTS REGARDING YOUR PHI

This section tells you about your rights regarding your PHI, and describes how you can exercise these rights.

Your right to access and amend your PHI
Subject to certain exceptions, you have the right to view or get a copy of your PHI that we maintain in records relating to your care or decisions about your care or payment for your care. Requests must be in writing.

After we receive your written request, we will let you know when and how you can see or obtain a copy of your record. If you agree, we will give you a summary or explanation of your PHI instead of providing copies. We may charge you a fee for the copies, summary or explanation.

If we do not have the record you asked for but we know who does, we will tell you who to contact to request it. In limited situations, we may deny some or all of your request to see or receive copies of your records, but if we do, we will tell you why in writing and explain your right, if any, to have our denial reviewed.

If you believe there is a mistake in your PHI or that important information is missing, you may request that we correct or add to the record. Requests must be in writing, telling us what corrections or additions you are requesting, and why the corrections or additions should be made. We will respond in writing after reviewing your request. If we approve your request, we will make the correction or addition to your PHI. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement.

Submit all written requests to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to choose how we send PHI to you or someone else
You may ask us to send your PHI to you at a different address (for example, your work address) or by different means (for example, fax instead of regular mail).

If your PHI is stored electronically, you may request a copy of the records in an electronic format offered by KPIC. You may also make a specific written request to KPIC to transmit the electronic copy to a designated third party.

If the cost of meeting your request involves more than a reasonable amount, we are permitted to charge you our costs that exceeds that amount.

Your right to an accounting of disclosures of PHI
You may ask us for a list of our disclosures of your PHI. Write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

An accounting does not include certain disclosures, for example, disclosures:

- to carry out treatment, payment and health care operations;
- for which KPIC had a signed authorization;
- of your PHI to you;
- for notifications for disaster relief purposes;
- to persons involved in your care and persons acting on your behalf; or
- not covered by the right to an accounting.

Your right to request limits on uses and disclosures of your PHI
You may request that we limit our uses and disclosures of your PHI for treatment, payment and health care operations purposes. We will review and consider your request. You may write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to receive a paper copy of this Notice
You have a right to receive a paper copy of this Notice upon request.

IV. HOW WE MAY USE AND DISCLOSE YOUR PHI

Your confidentiality is important to us. Our employees are required to maintain the confidentiality of the PHI of our insureds and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We briefly describe these uses and disclosures below and give you some examples.

How much PHI is used or disclosed without your written permission will vary depending, for example, on the intended purpose of the use or disclosure. Sometimes we may only need to use or disclose a limited amount of PHI, such as to confirm that you are KPIC-insured. At other times, we may need to use or disclose more PHI such as when we assist in resolving an appeal or grievance.

- **Payment**: Your PHI may be needed to determine our responsibility to pay for, or to permit us to bill and collect payment for, treatment and health-related services that you receive. When you or a provider sends us the bill for health care services, we use and disclose your PHI to determine how much, if any, of the bill we are responsible for paying.

- **Health care operations**: We may use and disclose your PHI for certain health care operations, for example, quality assessment and improvement, licensing, accreditation, activities relating to the creation, renewal or replacement of health insurance or health benefits; conducting medical review; legal services; auditing functions, including fraud and abuse detection and compliance programs; customer service, underwriting, and determining premiums and other costs of providing health care.

- **Business associates**: We may contract with business associates to perform certain functions or activities on our behalf, such as payment and health care operations. These business associates must agree to safeguard your PHI.

- **Specific types of PHI**: There are stricter requirements for use and disclosure of some types of PHI, for example, mental health and drug and alcohol abuse patient information, mental health records, and HIV tests, and genetic testing information. However, there are still circumstances in which these types of information may be used or disclosed without your authorization.

- **Underwriting**: We may use and disclose your PHI, to the extent permitted under applicable law, for underwriting purposes, including the determination of benefit eligibility and costs of coverage and to perform other activities related to issuing a benefit policy. However, we are prohibited from using or disclosing your genetic information for underwriting purposes. Your genetic information includes information about your genetic tests, your family members' genetic tests, and requests for or receipt of genetic services by you or any family members.

- **Communications with family and others when you are present**: Sometimes a family member or other person involved in your care will be present when we are discussing your PHI with you. If you object, please tell us and we won't discuss your PHI or we will ask the person to leave.

- **Communications with family and others when you are not present**: There may be times when it is necessary to disclose your PHI to a family member or other

person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

- **Disclosure in case of disaster relief**: We may disclose your name, city of residence, age, gender, and general condition to a public or private disaster relief organization to assist disaster relief efforts, unless you object at the time.

- **Disclosures to parents as personal representatives of minors**: In most cases, we may disclose your minor child's PHI to you. In some situations, however, we are permitted or even required by law to deny your access to your minor child's PHI. Examples of when we must deny such access include your minor child's PHI regarding drug or addiction, certain mental health services, and venereal disease.

- **Public health activities**: Public health activities cover many functions performed or authorized by government agencies to promote and protect the public's health and may require us to disclose your PHI.

  - For example, we may disclose your PHI as part of our obligation to report to public health authorities certain diseases, injuries, conditions, and vital events such as births. Sometimes we may disclose your PHI to someone you may have exposed to a communicable disease or who may otherwise be at risk of getting or spreading the disease.
  - The Food and Drug Administration (FDA) is responsible for tracking and monitoring certain medical products, such as pacemakers and hip replacements, to identify product problems and failures and injuries they may have caused. If you have received one of these products, we may use and disclose your PHI to the FDA or other authorized persons or organizations, such as the maker of the product.
  - We may use and disclose your PHI as necessary to comply with federal and state laws that govern workplace safety.

- **Health oversight**: As a health insurer, we are subject to oversight conducted by federal and state agencies. These agencies may conduct audits of our operations and activities and in that process, they may review your PHI.

- **Disclosures to your employer or your employee organization**: If you are enrolled in a KPIC health insurance plan through your employer or employee organization, we may share certain PHI with them without your authorization, but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf. For other purposes, such as for

inquiries by your employer or employee organization on your behalf, we will obtain your authorization when necessary under applicable law.

- **Workers' compensation**: We may use and disclose your PHI in order to comply with workers' compensation laws. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.

- **Military activity and national security**: We may sometimes use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal officials as necessary for national security and intelligence activities or for protection of the President and other government officials and dignitaries.

- **Required by law**: In some circumstances federal or state law requires that we disclose your PHI to others. For example, the Secretary of the Department of Health and Human Services may review our compliance efforts, which may include seeing your PHI.

- **Lawsuits and other legal disputes**: We may use and disclose PHI in responding to a court or administrative order, a subpoena, or a discovery request. We may also use and disclose PHI to the extent permitted by law without your authorization, for example, to defend a lawsuit or arbitration.

- **Law enforcemen**t: We may disclose PHI to authorized officials for law enforcement purposes, for example, to respond to a search warrant, report a crime on our premises, or help identify or locate someone.

- **Abuse or neglect**: By law, we may disclose PHI to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.

- **Coroners and funeral directors**: We may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. We may also disclose PHI to funeral directors.

- **Inmates**: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their PHI as other individuals. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or the law enforcement official for certain purposes, for example, to protect your health or safety or someone else's.

V. ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

Except for those uses and disclosures described above, we will not use or disclose your PHI without your written authorization. Some instances in which we may request your authorization for use or disclosure of PHI are:

- **Marketing**: We may ask for your authorization in order to provide information about products and services that you may be interested in purchasing or using. Note that marketing communications do not include our contacting you with information about treatment alternatives, prescription drugs you are taking or health-related products or services that we offer or that are available only to our health plan enrollees. Marketing also does not include any face-to-face discussions you may have with your providers about products or services.
- **Sale of PHI**: We may only sell your PHI if we received your prior written authorization to do so.

When your authorization is required and you authorize us to use or disclose your PHI for some purpose, you may revoke that authorization by notifying us in writing at any time. Please note that the revocation will not apply to any authorized use or disclosure of your PHI that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health insurance from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

VI. HOW TO CONTACT US ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice, or want to lodge a complaint about our privacy practices, please let us know by calling or writing to:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You also may notify the Secretary of the Department of Health and Human Services (HHS).

We will not take retaliatory action against you if you file a complaint about our privacy practices.

VII. CHANGES TO THIS NOTICE

We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. If we make an important change to our privacy practices, we will promptly change this Notice and notify you via the U.S. Postal Service that the change has been made along with instructions for obtaining the new notice.

Except for changes required by law, we will not implement an important change to our privacy practices before we revise this Notice.

VIII. EFFECTIVE DATE OF THIS NOTICE

This Notice is effective on September 23, 2013.

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE COVERAGE

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (the Act) was passed into law on October 21, 1998. The law requires group and individual health plans that provide mastectomy coverage, such as your plan coverage, to also provide coverage for:

1. reconstruction of both the diseased and non-diseased breast to produce symmetrical appearance; and
2. prostheses and treatment of physical complications at all stages of the mastectomy, including lypmhademas.

The Kaiser Permanente Insurance Company plan under which you are insured provides coverage for mastectomy and includes the services listed above when performed following a covered mastectomy.

If you have any questions about the coverage provided under the Act and your plan of insurance, please do not hesitate to contact us at the number listed on your insurance card.

Kaiser Permanente
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

KAISER PERMANENTE

Kaiser Permanente Insurance Company

000000074 084 EN2C IC PL GP [Mar.17,2021] OVC6BHOSPCDBLDHBMHOP5WSPVCKVOPT1NCDOP5YHEARF1EMER3JPV2XAFTR8UACUMCLALG4SALGTNAAMB3AAUTBB6CDIP2HCDRR31CHIR4QC
MPL--COIN20CRCS0ODED5IDEN--DIAL0UDMEB74DMESDRDPP--DUMYDMEMPH52EPOT--EXAB--FAMB8GRP36GYNICHC1IHCSS--HHBHOOP0BHOS2--HRA--INFT4MLAB3SMHBINAMHBONAMHIP17OPM6
YOVC2C5OXYG1BPNMT1UPP--REHBC2REOP6ISGOP26SNF2PSNKR--STU--TABS2ETRAN2ZTRGNCCTRVL--VADD--WLCH1GXPRO3BXRAY6BCDOP5YMHOP5WHEARF1SPVCKVOVC6BRX04HBBROK01D
OMP01GREX01GRFD02OAD6MOAS6MSRDC05SV02WORAN

000000074 084 PV15 IC ON GP [Mar.17,2021] OVCV0HOSPT1BLD4DMHOP65SPVCWAOPTC8CDOP45HEARG6EMER30PV3EAFTR4ZACUMCLALG4ZALGTNAAMB2EAUTBC4CDIP4HCDRR36CHIR--CMP
L--COIN26CRCS1LDED9SDEN--DIAL4ZDMEB90DMES2BDPP--DUMYDMEMPH5HEPOT--EXAB--FAMCCGRPFOGYNJBHC32HCSS--HHDHOOP0KHOS2--HRA--INFT4ULABD1MHBINAMHBONAMHIP21OPMP6
OVC299OXYG1MPNMT4ZPP--REHBC4REOP6ZSGOPCBSNF4PSNKR--STU--TABS2VTRAN4ZTRGN--TRVL--VADD--WLCH2YXPRO4ZXRAYH0CDOP45MHOP65HEARG6SPVCWAOVCV0RX034DBROK01DO
MP01GREX01GRFD02OAD6MOAS6MSRDC05SV02WORAN

EXHIBIT A-12
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-12: City and County of Denver Fire (74) POS 300 Certificate of Insurance.

KAISER PERMANENTE

Kaiser Permanente Insurance Company

Colorado

Point-of-Service

KAISER PERMANENTE

Kaiser Permanente Insurance Company

Mar.17,2021

Re: Policyholder: DENVER FIRE DEPARTMENT
Group Policy Number: 74-082

Dear Insured Employee:

Thank you for choosing Kaiser Permanente Insurance Company (KPIC).

Enclosed are your Certificate of Insurance and Schedule of Benefits for the current plan year. They supersede and replace any Certificate of Insurance or Schedule of Benefits that KPIC may have previously issued to you or your employer. The Certificate is evidence of your coverage under the KPIC Group Insurance Policy issued to your employer. Please read your Certificate carefully and keep it in a safe place.

If you have questions regarding your eligibility or plan benefits, please contact your employer.

Again, thank you for being a part of the Kaiser Permanente Health Care Program.

Sincerely,

KAISER PERMANENTE INSURANCE COMPANY

CO SUB Ltr.3

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

SCHEDULE OF BENEFITS (Who Pays What)

Group Name: DENVER FIRE DEPARTMENT **Group Number: 74-082**

Original Effective Date of Insurance: On File

COVERED PERSONS:	Employees and Dependents, if elected	
Dependent Child Age Limit:	Age 26, covered through the end of the month in which the age limit is reached	
LIFETIME MAXIMUM BENEFIT WHILE INSURED:	Not applicable	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Accumulation Period:	Calendar Year January 1- December 31	
Accumulation Period DEDUCTIBLES		
Self Only (Family of One Covered Person):	$300	$400
Individual (any one Covered Person in a family of two or more Covered Persons):	$300	$400
Family (for an entire family of two or more Covered Persons):	$900	$1,200
Accumulation Period OUT-OF-POCKET MAXIMUMS		
Self Only (Family of One Covered Person):	$3,000	$6,000
Individual (any one Covered Person in a family of two or more Covered Persons):	$3,000	$6,000
Family (for an entire family of two or more Covered Persons):	$9,000	$18,000

NOTE:

1. *Covered Charges applied to satisfy Deductibles and Cost Shares on Covered Services applied to satisfy Out-of-Pocket Maximums at the Participating Provider Tier will <u>not</u> be applied towards satisfaction of Deductibles and Out-of-Pocket Maximums at the Non-Participating Provider Tier. Likewise, Covered Charges applied to satisfy Deductibles and Cost Shares on covered Services applied to satisfy the Out-of-Pocket Maximums at the Non-Participating Provider Tier will <u>not</u> be*

applied towards satisfaction of Deductibles and Out-of-Pocket Maximums at the Participating Provider Tier.

2. *Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured or any dollar Benefit Maximum. Unless otherwise prohibited by applicable law, day or visit limits may be imposed upon Essential and non-Essential Health Benefits.*
3. *Deductible, Coinsurance and Co-payments do not apply to Preventive Benefits required under the Patient Protection Affordable Care Act (PPACA) at the Participating Provider Tier. Preventive Benefits required under the Patient Protection and Affordable Care Act (PPACA) that are received at the Non-Participating Provider Tier, however, are subject to Cost Sharing.*
4. *Covered non-preventive services provided during a preventive exam may be subject to the Deductible and applicable Copayments and Coinsurance.*

***IMPORTANT**: Read the section in Your Certificate of Insurance regarding Pre-certification carefully.*

No portion of a balance billing that exceeds the level of the Maximum Allowable Charge will count towards any Deductible, Coinsurance, or Out-of-Pocket Maximum, which is applicable under the Group Policy.

*For a complete understanding of the benefits, exclusions, and limitations applicable to your coverage, this **SCHEDULE OF BENEFITS (Who Pays What)** must be read in conjunction with the Certificate of Insurance.*

COVERED SERVICES	**YOUR COST SHARE (What You Pay)**	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Outpatient Services		
Office Visits:	Lab, X-ray and all other services are subject to Coinsurance after Deductible	Lab, X-ray services and all other services are subject to Coinsurance after Deductible
Primary Care:		
Office Visit	$20 Copayment per visit (Deductible does not apply)	40%
Virtual Care Services*:		
Video Visit	$20 Copayment per visit (Deductible does not apply)	40%
Email/Online Visit	$20 Copayment per visit (Deductible does not apply)	40%
Telephone Visit	$20 Copayment per visit (Deductible does not apply)	40%
*Includes Virtual Care Services obtained from Behavioral Health/Mental Health and Substance Use Disorder Providers		
Specialty Care:		
Office Visit	$35 Copayment per visit (Deductible does not apply)	40%
Virtual Care Services:		
Video Visit	$35 Copayment per visit (Deductible does not apply)	40%
Email/Online Visit	$35 Copayment per visit (Deductible does not apply)	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Telephone Visit	$35 Copayment per visit (Deductible does not apply)	40%
Allergy Diagnosis and Testing:		
By a Primary Care Provider	$20 Copayment per visit (Deductible does not apply)	40%
By a Specialty Care Provider	$35 Copayment per visit (Deductible does not apply)	40%
Allergy Treatment and Materials:		
Injection Visit:	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Serum:	20%	40%
Prenatal and postnatal Care:	20%	40%
Outpatient Surgery:	20%	40%
Chiropractic Care Spinal Manipulation Services:	$35 Copayment per visit (Deductible does not apply)	Not Covered
	Limited to a combined Benefit Maximum of 20 visits per Accumulation Period.	
Medically Necessary Bariatric Surgery:	Not Covered	Not Covered
Inpatient Hospital Care	20%	40%
Medically Necessary Bariatric Surgery:	Not Covered	Not Covered
Ambulance	Covered at the HMO In-Network Provider benefit level regardless of the participating status of the provider.	Covered at the HMO In-Network Provider benefit level regardless of the participating status of the provider.
Autism Spectrum Disorders		
Applied Behavior Analysis:	$20 Copayment per visit (Deductible does not apply)	40%
Physical, Occupational and Speech Therapy:	$20 Copayment per visit (Deductible does not apply)	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Behavioral Health/Mental Health Services		
Inpatient:	20%	40%
Outpatient:		
Individual Visits	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Group Therapy	$10 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Partial Hospitalization	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Dental		
Hospital services for dental procedures:	20%	40%
Dialysis Care	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only
Drugs, Supplies and Supplements		
Drugs administered in the Office Setting/Outpatient Hospital Setting:	20%	50%
Medical Foods:	$3 Copayment per product per day (Deductible does not apply)	$3 Copayment per product per day (Deductible does not apply)

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Outpatient Prescription Drugs:	Prescription Drug deductible: None Generic: $25 Copayment per prescription, Deductible does not apply Brand: $35 Copayment per prescription, Deductible does not apply Oral Anti-cancer Drugs: $35 Copayment per prescription, Deductible does not apply Diabetic Supplies: $25 Copayment per prescription, Deductible does not apply Day Supply: 30	Prescription Drug deductible: None Preferred Generic: 50%, Deductible does not apply Preferred Brand: 50%, Deductible does not apply Non-Preferred (Generic and Brand) Drugs: 50%, Deductible does not apply Specialty Drugs: 50%, Deductible does not apply Oral Anti-cancer Drugs: 50%, Deductible does not apply Diabetic Supplies: 20%, Deductible does not apply Day Supply: 30
Insulin	Applicable Cost Share Corresponding to the appropriate Formulary Tier Not to Exceed $100 Cost Share per prescription for a 30-day supply	Applicable Cost Share Corresponding to the appropriate Formulary Tier Not to Exceed $100 Cost Share per prescription for a 30-day supply
Mail Order	Same Coinsurance as retail, or if applicable, Co-payments payable for Mail Order service is 2 times the corresponding single Co-payment per prescription amount shown above, limited to a 90-day supply.	Not Available
Durable Medical Equipment/External Prosthetics and Orthotics		
Durable Medical Equipment and Orthotics:	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only
Oxygen:	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only
External Prosthetic Devices to replace an arm or a leg:	20% (Deductible does not apply)	20%
Dressings, casts and splints	20%	40%
Other covered External Prosthetic:	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Early Childhood Intervention Services	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)
	Limited to a combined Benefit Maximum of 45 Therapeutic Visits, per Accumulation Period, for Dependents from birth up to age 3	
Emergency Services	Covered at the HMO In-Network Provider benefit level regardless of the participating status of the provider.	Covered at the HMO In-Network Provider benefit level regardless of the participating status of the provider.
Hearing Services		
Routine Exam by Audiologist for Adults (age 18 and over):	Not covered	Not covered
Routine Exam by Audiologist for Minors (under the age of 18):	$20 Copayment per visit (Deductible does not apply)	40%
Hearing Aids for Adults (age 18 and over):	Not covered	Not covered
Hearing Aids Fitting and Recheck Visit for Adults (age 18 and over):	Not covered	Not covered
Hearing Aids for Minors (under the age of 18):	20%	40%
Hearing Aid Fitting and Recheck Visit for Minors (under the age of 18):	20%	40%
Home Health Care	20%	40%
	Limited to a combined Benefit Maximum of 60 Visits per Accumulation Period	
Hospice Care	20%	40%
Infertility Services		
Diagnosis and Treatment of Underlying Conditions	20%	40%
Artificial Insemination	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only
	Please refer to Reproductive Support Services in Health Plan's Evidence of Coverage to determine what services may be covered in the HMO In-Network Provider Tier.	

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Preventive Care Services		
Exams:	No Charge (Deductible does not apply)	40%
Screenings:	No Charge (Deductible does not apply)	40%
Health Promotion:	No Charge (Deductible does not apply)	40%
Listed Over-the-Counter Drugs and Over-the-Counter Contraceptives; and all Tobacco Cessation Drugs	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)
All other Contraceptives	No Charge (Deductible does not apply)	40%
Disease prevention:	No Charge (Deductible does not apply)	40%
Other Preventive Care:		
Family Planning:	20%	40%
Preventive Care Durable Medical Equipment:		
Peak Flow Meters	20% (Deductible does not apply)	Covered under Outpatient Prescription Drugs
Glucometers and Supplies	20% (Deductible does not apply)	20% (Deductible does not apply)
All Other Preventive Care	No Charge (Deductible does not apply)	40%
Rehabilitation and Habilitation Services		
Inpatient Multidisciplinary Rehabilitation or Habilitation Program, including one in Comprehensive Rehabilitation Facility:	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only
Outpatient:		
Pulmonary Therapy:	20%	40%
Cardiac Rehabilitation:	20%	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Rehabilitative Physical Therapy, Occupational Therapy and Speech Therapy:	20%	40%
	Limited to a combined Benefit Maximum of 20 visits per therapy, per Accumulation Period Visit Limits are not applicable to treat a Covered Person's congenital defects and birth abnormalities for physical, occupational and speech therapies from birth to age 6.	
Habilitative Physical Therapy, Occupational Therapy and Speech Therapy:	20%	40%
	Limited to a combined Benefit Maximum of 20 visits per therapy per Accumulation Period. Visit Limits are not applicable to treat a Covered Person's congenital defects and birth abnormalities for physical, occupational and speech therapies from birth to age 6.	
Skilled Nursing Facility Services	Covered in the HMO In-Network Provider Tier only	Covered in the HMO In-Network Provider Tier only
Substance Use Disorder Services		
Inpatient:	20%	40%
Outpatient:		
Individual Visits	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Group Therapy	$10 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%
Partial Hospitalization	$20 Copayment per visit, Deductible does not apply Other procedures performed during visits are subject to Deductible and Coinsurance	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
Transgender Surgery	Covered in the HMO-In-Network Provider Tier only	Covered in the HMO-In-Network Provider Tier only
Transplants	Covered in the HMO-In-Network Provider Tier only	Covered in the HMO-In-Network Provider Tier only
Urgent Care Facility Services	Covered at the HMO In-Network Provider benefit level regardless of the participating status of the provider.	Covered at the HMO In-Network Provider benefit level regardless of the participating status of the provider.
Vision Care		
Routine Eye Exam by Optometrist for:		
Minors	$20 Copayment per visit (Deductible does not apply)	40%
Adults	$20 Copayment per visit (Deductible does not apply)	40%
Routine Eye Exam by Specialist for:		
Minors	$35 Copayment per visit (Deductible does not apply)	40%
Adults	$35 Copayment per visit (Deductible does not apply)	40%
Refractive Eye Test by Optometrist for:		
Minors	20%	40%
Adults	20%	40%
Refractive Eye Test by Specialist for:		
Minors	20%	40%
Adults	20%	40%

COVERED SERVICES	YOUR COST SHARE (What You Pay)	
	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
X-Ray, Lab and Special Procedures		
Outpatient CT/MRI/PET and Nuclear Medicine Scans:	20%	40%
All other X-ray, Lab and Special procedures:	20%	40%
All Other Covered Services*	20%	40%

*Other Covered Services refer to Covered Services listed under the **BENEFITS/COVERAGE (What is covered)** Section of the Certificate of Insurance that are not detailed under the **SCHEDULE OF BENEFITS (Who Pays What)**. Unless otherwise stated, Your Cost Share for other Covered Services is as shown above. Unless specifically stated in this **SCHEDULE OF BENEFITS (Who Pays What)**, Other Covered Services are subject to applicable Coinsurance after Deductibles.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: KPIC Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

Kaiser Permanente Insurance Company

Colorado

Point of Service
Large Group
(*Non-grandfathered Coverage)*

Certificate of Insurance

TITLE PAGE (Cover Page)

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverage funded through a Group Insurance Policy issued to Your group by Kaiser Permanente Insurance Company. It becomes Your Certificate of Insurance when You have met certain eligibility requirements.

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit Payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. The Group Policy may be amended at any time without Your consent. If, any such amendment to the Policy is deemed to be a material modification, a 60-day prior notice will be sent to You before the effective date of the change. Any such amendment will not affect a claim initiated before the amendment takes effect. The Group Policy is available for inspection at the Policyholder's office.

This Certificate supersedes and replaces any and all certificates that may have been issued to You previously for the coverage described herein.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "we", "us", or "our". The Insured Employee named in the attached **SCHEDULE OF BENEFITS (Who Pays What)** section will be referred to as: "You", or "Your".

This Certificate is important to You, so please read it carefully and keep it in a safe place.

Please refer to the LIMITATIONS and EXCLUSIONS (What is Not Covered) section of this Certificate for a description of this health insurance plan's general limitations and exclusions. Likewise, the SCHEDULE OF BENEFITS (Who Pays What section contains specific limitations for specific benefits.

Note: If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in the TERMINATION/NON-RENEWAL/CONTINUATION section.

Colorado state law requires that an Access Plan be available that describes Kaiser Permanente Insurance Company (KPIC) Colorado's network of provider Services. To obtain a copy, please call **Customer Service** at 1-855-364-3184 or visit visit https://choiceproducts-colorado.kaiserpermanente.org/3-tier-point-of-service-plan/member-information/.

CONTACT US

Please read the HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFIT section carefully. It will help You understand how prior authorization requirements and the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services.

This Certificate uses many terms that have very specific definitions for the purpose of the Group Policy. These terms are defined in the **DEFINITIONS** section and are capitalized so that You can easily recognize them. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Group Policy are defined in those sections. Please read all definitions carefully.

This Certificate includes a **SCHEDULE OF BENEFITS (Who Pays What)** section that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Certificate of Insurance for a more complete description of Your coverage and the exclusions and limitations under this medical insurance plan.

This Certificate describes only the benefits of the Out-of-Network portion of Your Point-of-Service Plan. The Group Policy sets forth the complete terms of the coverage underwritten by KPIC. This Certificate forms the remainder of the Group Policy. The provisions set forth herein, are incorporated.

Who Can Answer Your Questions?
For assistance with questions regarding Your coverage, such as Your benefits, Your current eligibility status, or name and address changes, please have Your ID card available when You call:

1-855-364-3184 (Toll free)
711 (TTY)

Or You may write to the Administrator:

Kaiser Foundation Health Plan of Colorado
PO Box 370897
Denver, CO 80237-0897

For Pre-certification of Covered Services or Utilization Review of medical benefits other than Outpatient Prescription Drugs, please call the number listed on Your ID card or call 1-888-525-1553.

For Prior Authorization of certain Outpatient Prescription Drugs, please call the number listed on Your ID card or call 1-800-788-2949 (Pharmacy Help Desk).

TABLE OF CONTENTS

The sections of the Certificate appear in the order set forth below.
SCHEDULE OF BENEFITS (Who Pays What) section*

***Issued with this Certificate. Please consult Your Group Administrator if You did not receive a SCHEDULE OF BENEFITS (Who Pays What) section.**

ELIGIBILITY

The following persons will be eligible for insurance:

All employees of the Policyholder and their Dependents who are eligible for and enrolled under Health Plan as Point-of-Service Members.

Effective Date of an Eligible Employee's or Dependent's Insurance
The Effective Date of an employee's or Dependent's insurance will be the date the person becomes covered by Health Plan as a Point-of-Service Member.

Eligibility of an Eligible Employee's Dependent
See the Definition section for the definition of a Dependent.

Age Limits for Dependent Children
The age limit for Dependent children is under **26** years. If your employer elected to make coverage available under Your Plan beyond this age limit for Dependent children who are full-time students, then a Dependent child beyond this age limit who is a full-time student may be covered. The Dependent child must be of an age within the Student Age Limit as shown in your Schedule of Coverage. A **"full-time student"** is a Dependent child who is enrolled at a high school, college, university, technical school, trade school, or vocational school on a full-time basis. A **"full time student"** may also include, those who are on medical leave of absence from the school or those who have any other change in enrollment in school) due to a Medically Necessary condition as certified by the attending Physician. Such student coverage shall commence on the earlier of: the first day of the medical leave of absence; or on the date certified by the Physician. Coverage for students on medical leave of absence is subject to a maximum of 12 months and shall not continue beyond the effective date of the termination of the Group Policy.

Proof of status as a **"full time student"** must be furnished to KPIC at time of enrollment or within 31 days after attaining such status and subsequently as may be required by KPIC.

Exceptions
The Dependent Age Limit for Dependent Children does not apply to a Dependent child who is unmarried and continues to be both: 1) physically or mentally disabled and 2) dependent upon You for support and maintenance. Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the physically or mentally disabling sickness, injury or condition; or b) the date the child no longer depends on You for support and maintenance.

The above exception also applies to a **"full time student"** who is on medical leave of absence as described above, if, as a result of the nature of the sickness, injury, or condition, would render the dependent child physically or mentally disabled and dependent upon You for support and maintenance.

Proof of such incapacity and dependency must be submitted to KPIC within 60 days of Your receipt of KPIC's notice of the child's attainment of the limiting age and subsequently as may be required by KPIC, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

IMPORTANT:
KPIC will not deny enrollment of a child under the health insurance coverage of a child's parent because:
1. The child was born out of wedlock;
2. The child is not claimed as a Dependent on the parent's federal income tax return; or
3. The child does not reside with the parent or in an applicable service area.

ELIGIBILITY

Eligibility Date of Dependents
A Dependent's eligibility date is the later of: (a) Your eligibility date; or (b) the date the person qualifies as Your Dependent. A child named in a Qualified Medical Child Support Order qualifies as Your Dependent on the date specified in the court order. An adopted child qualifies as Your Dependent on the earlier of the date of adoption or the date of Placement for Adoption.

Enrollment Rules for Eligible Employee or Dependent
If you are an Eligible Employee, your and your Dependent's effective date of insurance is determined by the Enrollment Rules that follow.

1. **Initial Open Enrollment**
   The Policyholder will offer an initial open enrollment to new Eligible Employees and Dependents when the Employee is first eligible for coverage.

   Effective date. Initial enrollment for newly Eligible Employees and Dependents is effective following completion of any waiting period (not to exceed 90 days), if required by the Policyholder. In the absence of a waiting period, the enrollment becomes effective according to the eligibility rules established by the Policyholder.

   If You did not enroll Yourself and/or Your Dependents during the initial enrollment period, You will need to wait until the next annual open enrollment period to enroll or during the special enrollment period as described below.

2. **Annual Open Enrollment**
   Annual open enrollment refers to a standardized annual period of time, of no less than 30 days prior to the completion of the employer's plan year for Eligible Employees and Dependents to enroll. During the annual open enrollment period, Eligible Employees and Dependents can apply for or change coverage by submitting an enrollment application to your Group during the annual open enrollment period.

   Effective date. Enrollment is effective on the first day following the end of the prior plan year. Annual open enrollment occurs only once every year. The Policyholder will notify You when the annual open enrollment is available in advance of such period. Your Group will let you know when the annual open enrollment period begins and ends and the effective date.

3. **Special Enrollment**
   You or your Dependent may experience a qualifying event that allows a change in your enrollment. Examples of qualifying events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The qualifying event results in a special enrollment period that usually (but not always) starts on the date of the qualifying event and lasts for sixty (60) days. During the special enrollment period, you may enroll your Dependent(s) in this plan or, in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Kaiser Permanente and other requirements, call **Member Services** at 1-855-364-3184.

   Effective Date. In the case of birth, adoption, or placement for adoption, or placement in foster care, enrollment is effective on the date of birth, adoption, or placement for adoption or placement in foster care.

   In the case of any other qualifying event listed above, including marriage, civil union, or loss of coverage, enrollment is effective on the first day of the following month after We receive a fully completed enrollment form.

If You have Dependent coverage and there would be no extra cost for adding a Dependent to Your coverage, the effective date of insurance for a Dependent will be the date You acquire the Dependent. You must notify KPIC that You have a new Dependent within 31 days so that the Dependent can be added to

Your coverage. This will also help avoid delays on any claim You might file on behalf of the Dependent.

If the cost of Your Dependent coverage would increase when You add a Dependent, You must enroll the Dependent for insurance and agree to pay any additional cost in accordance with the Enrollment Rules. The effective date of insurance for that Dependent will be the date determined from the Enrollment Rules. If a Dependent does not enroll when eligible during the special enrollment period he/she may be excluded from all coverage until the next Annual Open Enrollment Period.

Court or Administrative Ordered Coverage for a Dependent Child
If a Covered Person is a non-custodial parent and is required by an Order to provide health coverage for an eligible child and the Covered Person is eligible for coverage under a family plan, the Covered Person, employee, employer or group administrator may enroll the eligible child under family coverage by sending KPIC a written application and paying KPIC any additional amounts due as a result of the change in coverage. Enrollment period restrictions will not apply in these circumstances. However, the child should be enrolled within 31 days of the court or administrative order to avoid any delays in the processing of any claim that may be submitted on behalf of the child. Coverage will not commence until the enrollment process has been completed.

If the Covered Person, employee, administrator, or employer fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, district attorney, child's legal custodian or the State Department of Health Services may submit the application for insurance for the eligible child. Enrollment period restrictions will not apply in these circumstances. However, the child must be enrolled within 31 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

The coverage for any child enrolled under this provision will continue pursuant to the terms of this health insurance plan unless KPIC is provided written evidence that:
1. The Order is no longer in effect;
2. The child is or will be enrolled in comparable health coverage through another insurer which will take effect on or before the requested termination date of the child's coverage under the Group Policy;
3. All family coverage is eliminated for members of the employer group; or
4. Nonpayment of premium.

Newborns
A newborn Dependent child is insured from birth, whether or not You have applied for coverage, for a period of 31 days.

If You are already insured for Dependent coverage, no further application is required to continue the child's coverage. If You are not already insured for Dependent coverage and if an additional premium is required for the child's coverage, You must apply for and pay the additional premium before the expiration of the 31-day period; otherwise the child's coverage will terminate after the 31-day period.

Coverage for newborn children will include coverage for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If the newborn child is born with cleft lip or cleft palate or both, care and treatment will include to the extent Medically Necessary:
1. Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
2. Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
3. Orthodontic treatment;
4. Prosthodontic treatment;
5. Habilitative speech therapy;
6. Otolaryngology treatment; and
7. Audiological assessments and treatment.

ELIGIBILITY

Adopted Children
Your adopted child is insured for the period of 31 days after the earlier of the date of adoption or the date of Placement for Adoption, whether or not You have applied for coverage.

If You are already insured for Dependent coverage, no further application is required to continue the child's coverage. If, however, You are not already insured for Dependent coverage and You are required to pay an additional premium for the child's coverage, You must apply for and pay the additional premium before the expiration of the 31-day period: otherwise, the child's coverage will terminate after the 31-day period.

The Health Plan Evidence of Coverage explains more fully the eligibility, effective date, and the termination provisions.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

This section describes how to access your services and how to obtain approval of certain benefits that are subject to Pre-certification.

Please read the following information carefully. It will help You understand how prior authorization requirements and the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services.

Under this Point of Service Plan, a Covered Person has access to three (3) tiers of coverage. The level of coverage that is applied to a Covered Service is dependent upon the provider's participating status and prior authorization requirements. Your provider and your provider's adherence to prior authorization requirements pursuant to state law affect whether the HMO Provider or the Participating Provider or Non- Participating Provider tiers of coverage applies to a Covered Service.

HMO Tier (Health Plan)

Kaiser Foundation Health Plan of Colorado (hereafter referred to as "Health Plan") provides the HMO coverage, which includes specified medical and Hospital services provided, prescribed, or directed by a Medical Group Physician, Affiliated Physicians and other Plan Providers (hereafter referred to as "Plan Providers") as these terms are defined in the Health Plan Evidence of Coverage. HMO services also include Emergency Care received from non-Plan Providers. These services rendered by Plan Providers are set forth in the Health Plan Evidence of Coverage issued to you separately. When a Plan Provider renders a Covered Service and the Health Plan's prior authorization rules are met, the service will be covered under the HMO Tier. Typically, benefits payable under the Health Plan Evidence of Coverage are greater for Covered Services received from Plan Providers than those benefits payable for Covered Services received from Participating Providers and Non-Participating Providers.

Participating Provider Tier and Non-Participating Provider Tier (KPIC)

Kaiser Permanente Insurance Company (KPIC) provides the Participating Provider and Non-Participating Provider benefit tiers of Your coverage. As reflected in Your **SCHEDULE OF BENEFITS (Who Pays What)** section, Your coverage also includes Covered Services received from Participating Providers as well as Non-Participating Providers. Generally, benefits payable under the Group Policy are greater for Covered Services received from Participating Providers than those benefits payable for Covered Services received from Non-Participating Providers. In order for benefits to be payable at the Participating Provider level under the Participating Provider Tier, the Covered Person must receive care from a Participating Provider. To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Provider directory is available from Your employer, or you may call the phone number listed on Your ID card or You may visit KPIC's website at http://kp.org/kpic-colorado or KPIC's contracted provider network web site at https://providerlocator.firsthealth.com/Kaiser.

If a Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy will be payable at the Non-Participating Provider level under the Non-Participating Provider Tier. However, if there are no Participating Providers within a reasonable distance per state regulation to provide a covered benefit, and as a result services are provided by a Non-Participating Provider, then the service will be covered at the Participating Provider level. Please notify us by calling **Customer Service** at 1-855-364-3184 if you are unable to locate a Participating Provider for a covered benefit.

In addition to higher Deductibles, Coinsurance or Copayments, a Non-Participating Provider may balance bill you. Balance billing occurs when a Non-Participating Provider bills you for the difference between the billed amount and Maximum Allowable Charge. Non-Participating Providers rendering services in Colorado are not allowed to balance bill You in any of the following circumstances:

- When you receive Emergency services in a Non-Participating facility or when Emergency services are rendered by physicians and other professionals that are Non-Participating Providers.
- When you receive Non-Emergency Services rendered in Participating facilities by physicians and

other professionals that are Non-Participating Providers.

NOTE: A Non-Participating Provider may balance bill you in the circumstances described above if you choose to use a Non-Participating Provider.

IMPORTANT NOTE:

- If a Covered Service is provided, arranged, paid for or payable by the Health Plan, no payment will be made by KPIC.
- Payments will be made by either Health Plan or KPIC but not both.
- The benefits provided by Health Plan under the HMO Tier and by KPIC under the Participating Provider and Non-Participating Provider Tiers are not the same. Some services are covered by both Health Plan and KPIC, and others are covered only by Health Plan or KPIC.
- In cases where a provider is contracted with both Health Plan and KPIC and the Health Plan's prior authorization requirements are met, pursuant to state law, the HMO level of coverage is applied to the treatment and services. If the Covered Service is not payable under the HMO coverage, it may be considered for payment under the Participating Provider level.
- Neither Health Plan nor KPIC is responsible for any Covered Person's decision to receive treatment, services or supplies by HMO Providers (Plan Providers) or by Participating Providers and Non-Participating Providers.
- Neither Health Plan nor KPIC is liable for the qualifications of providers or treatment, services or supplies provided under the other party's coverage.
- KPIC is not liable for the qualifications of providers or treatment, services or supplies provided by Participating or Non-Participating Providers.

For any questions regarding provider network participation please call **Customer Service** at 1-855-364-3184 (Toll free) or 711 (TTY)

Pre-certification through the Medical Review Program

This sub-section under the **HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS** section describes:

1. The Medical Review Program and Pre-certification procedures for medical benefits other than Outpatient Prescription Drugs;
2. How failure to obtain Pre-certification affects coverage;
3. Pre-certification administrative procedures; and
4. Which clinical procedures require Pre-certification.

If Pre-certification is not obtained, benefits payable by KPIC will be reduced by twenty percent (20%) each time Pre-certification is required. This 20% reduction will not count toward any Deductible, Coinsurance, or Out-of-Pocket Maximum applicable under the Group Policy. Such reduction only applies if You receive services, which have not been pre-certified, from a Non-Participating Provider, subject to the **IMPORTANT** note stated below.

IMPORTANT: Consistent with applicable Colorado law, the sole responsibility for obtaining any necessary Pre-certification regarding the utilization of the Participating Provider level of benefits rests with the Participating Provider, who recommends or orders Covered Services, and not with the Covered Person.

If You, however, received services from a Non-Participating Provider, and Pre-certification is not obtained, benefits payable by KPIC will be reduced even if the treatment or service is deemed Medically Necessary. If the treatment or service is deemed not to be Medically Necessary, the treatment or service will not be covered. If a Hospital Confinement or other inpatient care is extended beyond the number of days first pre-certified without further Pre-certification, benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered, if deemed not to be Medically Necessary.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

Program may be contacted twenty-four (24) hours a day, seven (7) days a week.

The following treatment or services must be pre-certified by the Medical Review Program when identified as a covered service (see the **SCHEDULE OF BENEFITS (Who Pays What)** section) under you plan:

1. All Inpatient admissions* and services including:
   a) Inpatient Rehabilitation Therapy Admissions including Comprehensive Rehabilitation Facility admissions related to services provided under an inpatient multidisciplinary rehabilitation program;
   b) Inpatient Mental Health and Substance Use Disorder admissions and services including Residential Services;
   c) Long Term Acute Care and Sub-acute admissions
2. Skilled Nursing Facility,
3. Non-Emergent Air or Ground Ambulance Transport
4. Amino Acid-Based Elemental Formulas
5. Clinical Trial
6. Medical Foods
7. Applied Behavior Analysis (ABA)
8. Cardiac Rehabilitation
9. Dental and Endoscopic Anesthesia
10. Durable Medical Equipment
11. Genetic Testing
12. Habilitative Services (Physical Therapy, Occupational Therapy and Speech Therapy)
13. Home Health and Home Infusion Services
14. Hospice Care
15. Imaging Services (Magnetic Resonance Imaging or MRI, Magnetic Resonance Angiography or MRA, Computerized Tomography or CT, Computerized Tomography Angiography or CTA, Positron Emission Tomography or PET, Electron Beam Computerized Tomography or EBCT, Single Photon Emission Computerized Tomography or SPECT)
16. Infertility Services
17. Observation stays
18. Outpatient Injectable Drugs
19. Outpatient Procedures
20. Outpatient Surgery
21. Pain Management Services
22. Prosthetic and Orthotic Devices
23. Radiation Therapy Services
24. Reconstructive Surgery
25. Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy, Speech Therapy and Pulmonary Therapy)
26. TMJ/Orthognathic Surgery
27. Transplant Services including pre-transplant and post-transplant services
28. Transgender Surgery Services

*Pre-certification is not required for emergency admissions. You or Your attending Physician should notify the Medical Review Program of the admission not later than twenty-four (24) hours following an emergency admission or as soon as reasonably possible.

NOTE: The above list is subject to change. For the most current information, please call the Medical Review Program at 1-888-525-1553 or 711 (TTY).

Pregnancy Pre-certification: When a Covered Person is admitted to a Hospital for delivery of a child, the Covered Person is authorized to stay in the hospital not less than:

1. Forty-eight (48) hours for a normal vaginal delivery; or
2. Ninety-six (96) hours for a Cesarean section delivery.

A stay longer than the above may be allowed provided the attending provider obtain authorization for an extended confinement through KPIC's Medical Review Program. In no case will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited above.

Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

Pre-certification Procedures
The Covered Person or the attending Physician must notify the Medical Review Program as follows:
1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally pre-certified.
3. Other treatments or procedures requiring Pre-certification - as soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Pre-certification but at least three days prior to performance of any other treatment or service requiring Pre-certification.
4. During the first trimester of pregnancy if the Covered Person intends to have Birth Services covered under this health insurance plan.
5. Hospital Confinement - as soon as reasonably possible upon stabilization following any emergency admission.

A Covered Person or the attending Physician must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:
1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second surgical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning, and long-term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service.

If the Covered Person or the attending Physician does not provide the necessary information or will not release the necessary information within the prescribed period as provided in the **APPEALS and COMPLAINTS** section on Pre-service Claim, We will make a decision based on the information We have.

Please refer to the **APPEALS AND COMPLAINTS** section on Pre-Service Claim of this Certificate of Insurance for Pre-certification request process. Also, refer to the same section where a benefit is denied, in whole or in part, due to a failure to obtain Pre-certification for services rendered by a Non-Participating Provider.

For prior authorization of certain Outpatient Prescription Drugs, please refer to the **BENEFITS/COVERAGE (What is Covered**) section under the Outpatient Prescription Drugs subsection.

BENEFITS/COVERAGE (What is Covered)

This section describes the **BENEFITS/COVERAGE (What is Covered)** provisions. See the **SCHEDULE OF BENEFITS (Who Pays What)** section to determine if the benefit is a covered service. General limitations and exclusions are listed in the **LIMITATIONS/EXCLUSIONS (What is Not Covered)** section.

Insuring Clause
Upon receipt of satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable of the Maximum Allowable Charge for Covered Charges incurred to treat a covered Injury or Sickness, provided:

1. The expense is incurred while the Covered Person is insured for this benefit;
2. The expense is for a Covered Service that is Medically Necessary;
3. The expense is for a Covered Service prescribed or ordered by the attending Physician or those prescribed or ordered by any other providers, who are duly licensed by the State to provide medical services without the referral of a Physician;
4. The Covered Person has satisfied the applicable Deductibles, Coinsurance, Copayments, and other amounts payable; and

5. The Covered Person has not exceeded the Maximum Benefit While Insured or any other maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** a section.

Payments under this Group Policy, to the extent allowed by law:

1. May be subject to the limitations shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section;
2. May be subject to the General Limitations and Exclusions; and
3. May be subject to Pre-certification.

Covered Services: Refer to the **DEFINITIONS** section for the meaning of capitalized terms. Unless specifically stated otherwise elsewhere in this Certificate of Insurance or in the **SCHEDULE OF BENEFITS (Who Pays What)** section, coverage is as follows:

Outpatient Care

1. Physicians' services including evaluation and management services during office visit or virtual care services consisting of Telehealth visits such as video visits; email/online visits; and telephone visits.
2. Nursing care by a Registered Nurse (RN) or, if none is available, as certified by the attending Physician, nursing care by a Licensed Vocational Nurse.
3. Services by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife, or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
4. Respiratory therapy rendered by a certified respiratory therapist.
5. Allergy testing materials and allergy treatment material.
6. Dressings, casts, splints.
7. Anesthesia and its administration by a licensed anesthesiologist or licensed nurse anesthetist.
8. Outpatient surgery or diagnostic procedures in a Free-Standing Surgical Facility or other licensed medical facility.
9. Hospital charges for use of a surgical room on an outpatient basis.
10. Pre-admission testing, limited to diagnostic, X-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made
11. Outpatient Birth Services in a Hospital, Birth Center or any other duly licensed facility. Pregnancy and Complications of Pregnancy will be covered on the same basis as any other physical Injury or Sickness.
12. Treatment of Intractable Pain, after reasonable efforts to cure or relieve the cause of the pain. Treatment for Covered Persons must be provided through one of the following:
    a. A primary care physician with documented experience in pain management and whose practice includes up-to-date treatment;
    b. A pain management specialist who is located in the State of Colorado;

c. A reasonably requested referral to a pain management specialist, if applicable.

13. Outpatient self-management training and education related to the care of diabetes, including equipment and supplies and medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items in accordance with applicable Colorado law. When prescribed, diabetes outpatient self-management and education must be provided by a certified, registered, or licensed health care professional with expertise in the care of diabetes.
14. Chemotherapy Services
15. Non-Dental Services to treat Temporomandibular Joint (TMJ) disorder.
16. Chiropractic Care Spinal Manipulation Services and supplies regardless of the license the provider performing the Service holds
17. Fecal Microbiota Treatment
18. Medically Necessary Bariatric Surgery Services
19. Necessary Services and Supplies

Inpatient Hospital Care

1. Room and Board in a Hospital, such as semi-private room or private room when a Physician determines it is medically necessary.
2. Room and Board in a Hospital Intensive Care Unit.
3. Respiratory therapy rendered by a certified respiratory therapist.
4. Physicians' services.
5. Nursing care by a Registered Nurse (RN) or, if none is available, as certified by the attending Physician, nursing care by a Licensed Vocational Nurse.
6. Services by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife, or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
7. Private duty nursing services in an inpatient hospital when medically necessary.
8. Dressings, casts, splints
9. Anesthesia and its administration by a licensed anesthesiologist or licensed nurse anesthetist.
10. Inpatient Birth Services in a Hospital, Birth Center or any other duly licensed facility. Pregnancy and Complications of Pregnancy will be covered on the same basis as any other physical Injury or Sickness.
11. Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) following a Cesarean section, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier. A stay longer than the above may be allowed provided the attending provider obtains Pre-certification for an extended confinement through KPIC's Medical Review Program. If the covered hospital stay for child birth ends after 8 p.m. coverage will be continued until 8 a.m. the following morning. In no case will KPIC require that a provider reduce the mother's or child's hospital confinement below the allowable minimum cited above.
12. Medically Necessary Bariatric Surgery Services
13. Necessary Services and Supplies.

Ambulance Services

Transportation by an ambulance service for non-Emergency Care when the use of other means of transportation would adversely affect Your condition. Emergency ambulance services received for an Emergency Medical Condition are covered under the HMO In-Network benefit described in the Health Plan Evidence of Coverage issued to you separately.

Autism Spectrum Disorders

Coverage for Autism Spectrum Disorders (ASD) is provided. The following services are in addition to, and not in lieu of, Early Childhood Intervention Services, as provided for under this Policy. Also, Covered Services provided for ASD are in addition to any service, which may be covered and rendered to a Dependent pursuant to an Individualized Family Service Plan, and Individualized Education Program or an Individualized Plan.

Coverage for ASD includes the following:
1. Evaluation for treatment and assessment services;
2. Behavior Training and behavior management and Applied Behavior Analysis, including, but not limited to: consultations, direct care, supervision or treatment, or any combination thereof;
3. Habilitative or Rehabilitative services;
4. Pharmacy Care which as covered under the Outpatient Prescription Drug benefit;
5. Psychiatric Care;
6. Psychological Care, including family counseling; and
7. Therapeutic Care.

The ASD Covered Services listed above, must be rendered in accordance with a Treatment Plan by an Autism Service Provider, as defined under this Policy. When rendered in accordance with a Treatment Plan, such Covered Services are considered to be appropriate, effective, and efficient for the purpose of treating ASD, and not to be regarded as either experimental or investigational.

Behavioral Health and Mental Health Services

Diagnosis, treatment, services, or supplies are covered under this Group Policy for Behavioral Health and Mental Health disorders, except Autism Spectrum Disorder or ASD, when received as an inpatient or on an outpatient basis in an office, Hospital, Residential Treatment facility or other licensed medical facility including a community mental health facility, and when diagnosed and treated by a provider duly licensed to diagnosis and treat such conditions. Coverage for Autism Spectrum Disorder or ASD is described under a separate header in this section.

Benefits will be limited to treatment, services or supplies otherwise covered under this Group Policy and will be provided on the same terms and conditions and no less extensive than, those provided for the treatment and diagnosis of other physical diseases or disorders.

Services include:
1. Inpatient Hospital services such as testing, treatment, therapy including electroconvulsive therapy, and counseling.
2. Partial hospitalization. Intensive and structured outpatient treatment offered for several hours during the day or evening. Services can be as intensive as inpatient care but do not require an overnight confinement in an inpatient hospital setting.
3. Outpatient and Office based services such as testing, treatment, therapy and counseling.

Clinical Trials

We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
1. We would have covered the Services if they were not related to a clinical trial.
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Physician makes this determination.
   b. You provide us with medical and scientific information establishing this determination.
3. If any Participating Provider participates in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i) The National Institutes of Health.
      ii) The Centers for Disease Control and Prevention.
      iii) The Agency for Health Care Research and Quality.

iv) The Centers for Medicare & Medicaid Services.
v) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
vii) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
    1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
    2. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the **SCHEDULE OF BENEFITS (Who Pays What)** section for the Cost Share that applies to hospital inpatient care.

Clinical trials exclusions
1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Dental Services
1. Hospitalization and Anesthesia for Dental Procedures. Covered Services includes hospitalization and general anesthesia administered to a covered Dependent child for dental procedures. The general anesthesia must be provided in a Hospital, outpatient surgical facility, or other licensed facility Treatment must be provided by an anesthesia provider who is either:
    a) An educationally qualified specialist in pediatric dentistry; or
    b) Any other dentist who is educationally qualified in a recognized dental specialty for which Hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate Hospital training to be granted Hospital privileges.

    In order for the child's hospitalization and general anesthesia to be covered, the child's treating dentist must provide a written opinion to KPIC indicating that:
    a) The Dependent child has a physical, mental, or medically compromising condition; or
    b) The Dependent child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
    c) The Dependent child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
    d) The Dependent child has sustained extensive orofacial and dental trauma.

This provision does not apply to treatment rendered for temporomandibular joint disorders.
This provision does not provide coverage for any dental procedure or the services of the dentist.

2. Medically necessary orthodontia limited to dental services within the mouth for treatment of a condition related to or resulting from cleft lip and/or cleft palate.

Dialysis Care
Dialysis services related to acute renal failure and end-stage renal disease including dialysis equipment; training; and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Drugs, Supplies and Supplements
1. Drugs and materials that require supervision or administration by medical personnel during a covered hospital confinement or other covered treatment.

2. Medical Foods, as defined, when related to the treatment of inherited enzymatic disorders caused by single-gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions include, but are not limited to the following diagnosed conditions: phenylketonuria (PKU), maternal PKU, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia, and propionic acidemia, immunoglobin E and immunoglobin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of gastrointestinal tract. Medical Foods may also be for home use, for which a Participating Physician has ordered a prescription, whether written, oral or electronic transmission. Except for PKU, there is no age limit on benefits for inherited enzymatic disorders, as specified above. The maximum age to receive benefits for PKU is twenty-one (21) years of age except that the maximum age to receive benefits for PKU for women, who are of child-bearing age, is thirty-five (35) years of age.

Outpatient Prescription Drugs

Covered Charges include charges for drugs or medicines or supplies purchased from a licensed pharmacy on an outpatient basis provided they:

a) Can be lawfully obtained only with the written prescription of a Physician or prescribing provider or dentist;
b) Are purchased by Covered Persons on an outpatient basis;
c) Are covered under the Group Plan; and
d) Do not exceed the maximum daily supply shown in th**e SCHEDULE OF BENEFITS (Who Pays What)** section, except that in no case may the supply be larger than that normally prescribed by a Physician or prescribing provider or dentist.

Such charges are subject to all of the terms and conditions of the Group Policy including Deductible, Copayment, Coinsurance, exclusions and limitations, unless otherwise set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Drugs Covered:

Covered Charges for outpatient prescription drugs are limited to charges from a licensed pharmacy for:

1. Any medication whose label is required to bear the legend “Caution: federal law prohibits dispensing without a prescription.” Experimental drugs are not covered unless one or more of the following conditions are met:
   a) The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
   b) The drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.
2. A prescription legend drug for which a written prescription is required;
3. Non-injectable legend drugs (to include legend maintenance drugs). See exclusions list below for exceptions;
4. Compounded medication of which at least one ingredient is a legend drug;
5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber;
6. Legend prenatal vitamins.
7. Specialty Drugs such as self-administered injectable medications, as indicated in the Preferred Drug List, are covered, subject to the following conditions:
   a) The medication does not require administration by medical personnel;
   b) The administration of the medication does not require observation;
   c) The patient’s tolerance and response to the drug does not need to be tested, or has been satisfactorily tested; and
   d) The medication has been prescribed for self-administration at home.
   e) Self-administered injectable medications must be written on a prescription filled by a pharmacy, and self-administered by the patient or caregiver at home (not administered by providers in medical offices.

8. Prescribed oral anti-cancer medication, which has been approved by the Federal Food and Drug Administration, at a cost not to exceed the coinsurance or the co-payment level as any intravenously administered or an injected cancer medication prescribed for the same purpose.
9. Insulin and the following diabetic supplies, unless related to the Covered Service for outpatient self-management of diabetes as described in the **BENEFITS/COVERAGE (What is Covered)** section:
   a) Home glucose monitoring supplies are covered under Other Preventive Care section;
   b) Syringes and needles;
   c) Acetone and glucose test tablets; and
   d) Glucose test strips
10. Prescription drugs and prescribed over the counter medicines for smoking cessation are covered under Your Preventive Care Services.
11. Prescription contraceptive drugs or devices are covered under Your Preventive Care Services.
12. Off-label use of drugs used for the treatment of cancer if the drug is recognized for the treatment of cancer in the authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Services.
13. Renewal of prescription eye drops when: (a) the request for renewal is made:(i) at least 21 days for a 30-day supply or (ii) at least 42 days for a 60-day supply or (iii) at least 63 days for a 90-day supply, from the later of the date the original prescription was dispensed or last renewed and (b) the original prescription states that additional quantities are needed and the renewal request does not exceed the number of additional quantities needed. One additional bottle (limited to one bottle every 3 months) of prescription eye drops is covered when: (a) the additional bottle is requested at the time the original prescription is filled; and (b) the original prescription states that it is needed for use in a day care center, school or adult day program.
14. A five-day supply of at least one of the FDA-approved drugs for the treatment of opioid dependence limited to a first (1st) request within a 12-month period.

Coverage under Other Policy Provisions: Charges for services and supplies not subject to Prior Authorization that qualify as Covered Charges under this benefit provision will not qualify as Covered Charges under any other benefit provision of the Group Policy.

This Outpatient Prescription Drug Benefit uses an open Formulary. An open Formulary is a list of all FDA-approved drugs unrestricted drugs or devices unless specifically excluded under the plan. The Formulary consists of preferred generic and brand drugs and non-preferred generic and brand drugs and specialty drugs. Please visit https://kp.org/kpic-colorado for the Drug Formulary. Your Outpatient Prescription Drug Benefit is subject to the following utilization management requirements:

Quantity Limits
Quantity limits apply to outpatient prescription drugs for safety and cost reasons and follow the manufacturer's FDA-approved guidelines from their package inserts. Prescribers must obtain authorization for quantities higher than those allowed under the utilization management program.

Age Limits
Age requirements/limits apply to some outpatient prescription drugs and are part of the utilization management program to help ensure You are receiving the right medication at the right time. Such limits restrict coverage for a drug to a certain age for reasons of safety and/or efficacy and as may be recommended to be necessary to promote appropriate use. In addition to age limitations determined by FDA-approved guideline, outpatient prescription drugs will be subject to requirements based on the recommendations of the U.S. Preventative Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC).

Step Therapy process
Selected prescription drugs require step therapy. Step therapy is a process that defines how and when a particular outpatient prescription drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through Your drug history, prior to the use of another drug (2nd line agent). The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain high-cost medications. Refer to the formulary for a complete list of medications requiring step therapy. This means that to receive coverage You may first

need to try a proven, cost-effective medication before using a more costly medication. Treatment decisions are always between You and Your Prescribing Provider. Refer to the Formulary for a complete list of medications requiring step therapy. The following outpatient prescription drugs shall not be subject to any Step Therapy requirement: (1) FDA-approved medication for the treatment of substance use disorder; (2) FDA-approved medication for the treatment of Stage four (4) advanced metastatic cancer; and (3) FDA-approved medication for the prevention of HIV infection when prescribed and dispensed by a pharmacist. For purpose of this provision medications for the prevention of HIV infection include pre-exposure, post exposure or other drugs approved by the FDA for the preventive of HIV infection.

Your Prescribing Provider should prescribe a first-line medication appropriate for Your condition. If Your Prescribing Provider determines that a first-line drug is not appropriate or effective for You, a second-line drug may be covered after meeting certain conditions.

Prior Authorization
Prior Authorization is a review and approval procedure that applies to some outpatient prescription drugs and is used to encourage safe and cost-effective medication use. Prior authorization is generally applied to outpatient prescription drugs that have multiple uses, are higher in cost, or have a significant safety concern. The following outpatient prescription drugs shall not be subject to Prior Authorization: (1) FDA-approved medication for the treatment of substance use disorder; and (2) FDA-approved medication for the prevention of HIV infection when prescribed and dispensed by a pharmacist. For purpose of this provision, medications for the prevention of HIV infection include pre-exposure, post-exposure or other drugs approved by the FDA for the prevention of HIV infection.

The purpose of Prior Authorization is to ensure that You receive the right medication for Your medical condition. This means that when Your Prescribing Provider prescribes a drug that has been identified as subject to Prior Authorization, the medication must be reviewed by the utilization management program to determine Medical Necessity before the prescription is filled. Prior authorization reviews address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires prior authorization, Your Prescribing Provider must work with Us to authorize the drug for Your use. Drugs requiring Prior Authorization have specific clinical criteria that You must meet for the prescription to be eligible for coverage. Refer to the formulary for a complete list of medications requiring Prior Authorization. The most current formulary can be obtained by visiting https://kp.org/kpic-colorado. If You have questions about the Prior Authorization or about outpatient prescription drugs covered under Your plan, you can call 1-800-788-2949 (Pharmacy Help Desk) or 711 (TTY) 24 hours a day, 7 days a week (closed holidays).

Definitions specific to the Prior Authorization of Outpatient Prescription Drug and Step Therapy provisions:

"Prior Authorization" means certain covered outpatient prescription drugs will require an approval where the prescribed medication will be reviewed by Us to determine Medical Necessity before the prescription is filled. This approval process is called the prior authorization process.

"Urgent Prior Authorization Request" means:
A request for prior authorization when based on the reasonable opinion of the Prescribing Provider with knowledge of the Covered Person's medical condition, the time frames allowed for non-urgent prior authorization:

a) Could seriously jeopardize the life or health of the covered person or the ability to regain maximum function; or
b) The Covered Person is subject to severe pain that cannot be adequately managed without the drug benefit that is the subject of request for prior authorization.

"KPIC's Uniform Pharmacy Prior Authorization Request Form" means the standardized prescription drug prior authorization form prescribed by the Colorado Division of Insurance (DOI) that will be used under applicable Colorado state law and regulation.

"Prescribing Provider" means a provider licensed and authorized to write a prescription pursuant to

applicable state law to treat a medical condition of a Covered Person.

When an outpatient prescription drug requiring Prior Authorization has been prescribed, You or Your Prescribing Provider must notify the utilization management program as follows:

1. Complete and submit KPIC's Uniform Pharmacy Prior Authorization Request Form available on-line at https://kp.org/kpic-colorado to the utilization management program as described in item 2 below. You or Your Prescribing Provider can also obtain a copy of KPIC's Uniform Prior Authorization Request Form by calling 1-800-788-2949. Prior authorization requests contained on a form other than KPIC's Uniform Pharmacy Prior Authorization Request Form will be rejected.

2. We will accept KPIC's Uniform Pharmacy Prior Authorization Request Form through any reasonable means of transmission, including, but not limited to, paper, electronic, or any other mutually accessible method of transmission, by sending it via fax at 1-858-790-7100.

3. Within one (1) business day upon Our receipt of a completed Urgent Prior Authorization Request, We will process the Urgent Prior Authorization Request and we will notify You or Your Prescribing Provider and dispensing pharmacy (if applicable) that:
   a) The request is approved; or
   b) The request is denied for any of the following reasons:
      i) Not Medically Necessary;
      ii) The patient is no longer eligible for coverage;
      iii) The request is not submitted on the prescribed KPIC's Uniform Pharmacy Prior Authorization Request Form and must be resubmitted using the prescribed request form.
   c) There is missing material information necessary to determine Medical Necessity. We will notify and request Your Prescribing Provider to submit additional information needed to process the Urgent Prior Authorization Request.
      i) Upon receipt of Our request for additional information, Your Prescribing Provider has a period of two (2) business days within which to submit the requested information; and
      ii) Upon Our receipt of the requested additional information from Your Prescribing Provider, we shall make a determination within one (1) business day of receipt.
      iii) However, upon failure by Your Prescribing Provider to submit the requested additional information within two (2) business days, the Urgent Prior Authorization Request shall be deemed denied; and
      iv) We will provide You, Your Prescribing Provider or dispensing pharmacy (if applicable) with the confirmation of the denial within one (1) business day from the date the Urgent Prior Authorization Request was deemed denied.

4. Within two (2) business days upon receipt of a completed Non-Urgent Prior Authorization Request submitted electronically and within three (3) business days upon receipt of a completed Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation, We will process and notify You, Your Prescribing Provider and dispensing pharmacy (if applicable) that:
   a) The request is approved;
   b) The request is denied for any of the following reasons:
      i) Not Medically Necessary;
      ii) The patient is no longer eligible for coverage;
      iii) The request is not submitted on the prescribed KPIC Uniform Pharmacy Prior Authorization Request Form and must be resubmitted using the prescribed request form.
   c) There is missing material information necessary to determine Medical Necessity. We will notify and request Your Prescribing Provider to submit additional information needed to process the Non-Urgent Prior Authorization Request.
      i) Upon receipt of Our request for additional information, Your Prescribing Provider has a period of two (2) business days within which to submit the requested information; and
      ii) Upon Our receipt of the additional information from your Prescribing Provider, We shall make a determination within two (2) business days for Non-Urgent Prior Authorization Request submitted electronically and within three (3) business days for Non-Urgent Prior Authorization

Request submitted via fax or electronic mail or verbally with associated written confirmation.

iii) However, upon failure by Your Prescribing Provider to submit the requested additional information within two (2) business days, the Non-Urgent Prior Authorization Request shall be deemed denied.

iv) We will provide You, Your Prescribing Provider and dispensing pharmacy (if applicable) with the confirmation of the denial within two (2) business days from the date the Non-Urgent Prior Authorization Request was deemed denied.

5. The Request shall be deemed to have been approved for failure on Our part to:
   a) Request additional information from Your Prescribing Provider; or
   b) To provide the notification of approval to You and Your Prescribing Provider; or
   c) To provide the notification of denial to You and Your Prescribing Provider within the required time frames set forth above from Our receipt of an Urgent Prior Authorization Request or a Non-Urgent Prior Authorization Request from Your Prescribing Provider.

6. We shall provide You, Your Prescribing Provider and the dispensing pharmacy (if applicable) with a confirmation of the deemed approval, as follows:
   a) For Urgent Prior Authorization Request - within one (1) business day of the date the request was deemed approved;
   b) For Non-Urgent Prior Authorization Request submitted electronically – within two (2) business days of the date the request was deemed approved; and
   c) For Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation – within three (3) business days of the date the request was deemed approved.

7. A Prior Authorization approval is valid for a period of one hundred eighty (180) days after the date of approval.

8. In the event Your Prescribing Provider's Prior Authorization Request is disapproved:
   a) The notice of disapproval will contain an accurate and clear written explanation of the specific reasons for disapproving the request.
   b) If the request is disapproved due to missing material information necessary to determine Medical Necessity, the notice of disapproval will contain an accurate and clear explanation that specifically identifies the missing material information.

9. Notices required to be sent to You or Your authorized representative or Your Prescribing Provider or dispensing pharmacy (if applicable) shall be delivered by Us in the same manner as the Prior Authorization Request Form was submitted to Us, or any other mutually agreeable accessible method of notification.

10. Prescription drug prior authorization procedures conducted electronically through a web portal, or any other manner of transmission mutually agreeable, shall not require You or Your Prescribing Provider to provide more information than is required by the KPIC's Uniform Pharmacy Prior Authorization Request Form.

<u>Exception Requests for Prior Authorization, Step Therapy, Quantity and Age Limits</u>

You or Your authorized representative or the Prescribing Provider may request an exception or a waiver to the Outpatient Prescription Drug Prior Authorization Request, Step Therapy process, Quantity and Age Limits described above if You are already being treated for a medical condition and currently under medication of a drug subject to Prior authorization or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition.

You may request to waive Step Therapy if the drug is on Our Formulary, You have tried the step therapy-required prescription drug while under Your current or previous health insurance and such prescription drugs were discontinued due to lack of effectiveness, diminished effect or an adverse event. We may require you to submit relevant documentation to support Your request.

However, further Prior Authorization may be required for the continued coverage of a prescription drug prescribed pursuant to a Prior Authorization or Step Therapy process imposed from a prior insurance policy.

To request for an exception or waiver, please call:1-800-788-2949 (Pharmacy Help Desk).

If Your request for Outpatient Prescription Drug Prior Authorization or waiver of the Step Therapy process, Quantity and Age limits, is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **APPEALS AND COMPLAINTS** section for a detailed discussion of the grievance and appeals process and Your right to an External Review.

Exclusions for Outpatient Prescription Drug Benefits.
The following are not covered under the Outpatient Prescription Drug Benefit:

1. Internally implanted time-release medications, except contraceptives required by law;
2. Compounded dermatological preparation, which must be prepared by a pharmacist in accord with a Physician's prescription, with ingredients of which are available over the counter;
3. Antacids;
4. For Covered Persons with enterostomies and urinary diversions, the following ostomy supplies and equipment:
   a) Appliances
   b) Adhesives
   c) Skin barriers and skin care items
   d) Belts and clamps
   e) Internal and appliance deodorants
5. Drugs when used for cosmetic purposes, including Ioniten (Minoxidil) for the treatment of alopecia, Tretinon (Retin A) for individuals 26 years of age or older and anti-wrinkle agents (e.g., Renova);
6. Non-legend drugs and non-legend vitamins;
7. Therapeutic devices or appliances, support garments and other non-medical substances, regardless of intended use, unless specifically listed above;
8. Charges for the administration or injection of any drug;
9. Drugs labeled "Caution - limited by federal law to investigational use." or experimental drugs, even though a charge is made to the individual, unless for the treatment of cancer as specified in item 1 under Drugs Covered;
10. Hematinics;
11. DESI Drugs - drugs determined by the FDA as lacking substantial evidence of effectiveness;
12. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institutions which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
13. Minerals;
14. Infertility Medications;
15. Anorectic drugs (any drug used for the purpose of weight loss);
16. Fluoride supplements except as required by law;
17. Tobacco cessation products except as described under Preventive Care Services.

Dispensing Limitations: KPIC will not pay for more than the per prescription or refill supply set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section. In no case, however, may the supply be larger than that normally prescribed by a Physician or other lawful prescriber.

Direct Reimbursement
If you paid the full price for your covered prescription, you may request a direct reimbursement from us subject to the applicable Cost Share.

To submit a claim for direct reimbursement you may access the direct member reimbursement form via https://mp.medimpact.com/mp/public/Frameset.jsp?forwardUrl=/mp/public/HelpDesk.jsp to find the direct member reimbursement form or for assistance you may call the MedImpact Customer Contact Center 24 hours a day 7 days a week at 1- 800-788-2949 (Pharmacy Help Desk) or email via customerservice@medimpact.com

Durable Medical Equipment/External Prosthetics and Orthotics

1. Rental of Durable Medical Equipment. Purchase of such equipment may be made if in the judgment of KPIC:
   a) purchase of equipment would be less expensive than rental; or
   b) such 7equipment is not available for rental.
2. Prosthetic devices (External) are covered including:
   a) external prosthetics related to breast reconstruction resulting from a covered mastectomy; or
   b) when necessary, to replace, in whole or in part, an arm or a leg; or
   c) required to treat cleft lip or cleft palate such as obturators, speech and feeding appliances
3. Prosthetic devices (internally implanted) are covered as part of the surgical procedure to implant them.
4. Orthotics including diabetic shoes are covered. Repair or replacement of orthotic devices are covered. Repair or replacement of orthotic devices due to loss or misuse is not covered.

Early Childhood Intervention Services

Eligible Insured Dependents, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for Early Intervention Services (EIS) up to the maximum number of visits as determined by the State.

Coverage of Early Childhood Intervention Services does not include any of the following:

1. Respite care;
2. Non-emergency medical transportation;
3. Service coordination, as defined by applicable Colorado law; and
4. Assistive technology that is not included as Durable Medical Equipment, which is otherwise covered under the Group Policy.

Emergency Services

Emergency Services are covered 24 hours a day, 7 days a week, anywhere in the world. If You have an Emergency Medical Condition, call 911 or go to the nearest emergency room.

Emergency Services received for an Emergency Medical Condition are covered under the HMO In-Network benefit described in the Health Plan Evidence of Coverage issued to you separately. Covered Services received in an Emergency Department that do not meet the definition of an Emergency Medical Condition will be covered as indicated in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Family Planning Services – See Preventive Care and Services

Hearing Services

Limited only to minor Dependents under the age of 18:

1. Hearing exams and tests by audiologists to determine the need for hearing correction.
2. For minor Dependents with a verified hearing loss, coverage shall also include:
   a) Initial hearing aids and replacement hearing aids not more frequently than every 5 years;
   b) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Home Health Care

Home Health Services. The following services provided by a Home Health Agency under a plan of care to Covered Persons in their place of residence are covered:

1. Skilled nursing services;
2. Certified or licensed nurse aid services under the supervision of a Registered Nurse or a qualified therapist;
3. Physical therapy;
4. Occupational therapy;
5. Speech therapy and audiology;
6. Respiratory and inhalation therapy;

7. Nutrition counseling by a nutritionist or dietitian;
8. Medical social services, medical supplies; prosthesis and appliances suitable for home use; rental or purchase of durable medical equipment; and
9. Drugs, medicines, or insulin

Home health services do not include:
1. Food services or meals, other than dietary counseling;
2. Services or supplies for personal comfort or convenience, including Homemaker Services; and
3. Services related to well-baby care.

Covered Home Health Services are limited to intermittent care services. Intermittent care services means services are limited to 28 hours per week and less than 8 hours a day.

Such services must be provided in the Covered Person's home and according to a prescribed treatment plan established by a Physician in collaboration with the home health provider. Home health care must be required in lieu of hospitalization or in place of hospitalization. Services of up to four hours by a home health aide shall be considered as one visit.

Hospice Care
This provision only applies to a Terminally Ill Covered Person with a life expectancy of less than six (6) months receiving Medically Necessary care under a Hospice Care program. Benefits may exceed six (6) months should the Terminally Ill Covered Person continue to live beyond the prognosis for life expectancy. Covered Services include Hospice Care Benefits when a Covered Person's Physician provides KPIC a written certification of the Covered Person's Sickness along with a prognosis of life expectancy; and a statement that Hospice Care is Medically Necessary.

A copy of the Hospice program's treatment plan may be required before benefits will be payable.

Hospice Care benefits are limited to:
1. Physician services
2. Nursing care, including care provided by a Licensed Vocational Nurse or Certified Nurse's Aide, when under the supervision of a Registered Nurse or specialized rehabilitative therapist;
3. Physical, speech or occupational therapy and audiology;
4. Respiratory and inhalation therapy including oxygen and respiratory supplies;
5. Medical social services;
6. Nutrition counseling by a nutritionist or dietitian;
7. Rental or purchase of durable medical equipment;
8. Prosthetic and orthopedic appliances;
9. Medical supplies including drugs and biologicals;
10. Diagnostic testing necessary to manage the terminal illness;
11. Medically necessary transportation needed for hospice services;
12. Family counseling related to the Covered Person's terminal Sickness including bereavement support; and
13. Respite care.

Covered Persons who elect to receive Hospice Care are not entitled to any other benefits under the Group Policy for the terminal Sickness. Services and charges incurred by the Covered Person in connection with an unrelated illness will be processed in accordance with coverage provisions applicable to all other illnesses and/or injuries.

No payments will be made for expenses that are part of a Hospice Care program that started after coverage under the Group Policy ceases.

Infertility Services
Services required to establish a diagnosis of infertility are covered. Services to treat underlying medical conditions that cause infertility such as endometriosis and obstructed fallopian tubes are covered. Artificial insemination which includes intrauterine insemination (IUI) is covered.

BENEFITS/COVERAGE (What is Covered)

Preventive Care Services

Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services. Please refer to Your **SCHEDULE OF BENEFITS (Who Pays What)** section regarding each benefit in this section:

As shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section as a Covered Service, the following Preventive Services are covered under this Policy and are not subject to Deductibles, Co-payments or Coinsurance if received from Participating Providers. Consult with Your physician to determine what preventive services are appropriate for You.

1. Exams:
   a) Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines
   b) Well woman exam visits including preconception counseling and routine prenatal office visits Routine prenatal office visits include the initial and subsequent histories, physical examinations, recording of weight, blood pressure, fetal heart tones, and routine chemical urinalysis according to the Health Resources and Services Administration (HRSA) guidelines).

2. Screening:
   a) Abdominal aortic aneurysm screening
   b) Anxiety screening in adolescent and adult women including those who are pregnant or post-partum
   c) Asymptomatic bacteriuria screening
   d) Breast cancer mammography screening
   e) Cervical dysplasia screening including HPV screening,
   f) Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, over the counter and prescription drugs necessary to prepare the bowel for the procedure, and a specialist consultation visit prior to the procedure.
   g) Depression screening
   h) Diabetes screening for non-pregnant women with a history of diabetes who have not previously been diagnosed with type 2 diabetes mellitus
   i) Gestational Diabetes screening
   j) Hepatitis B and Hepatitis C virus infection screening
   k) Hematocrit or Hemoglobin screening in children
   l) High blood pressure screening
   m) Lead Screening
   n) Lipid disorders screening to determine need for statin use
   o) Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screening (in adults who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. One pack year is equal to smoking one pack per day for one year, or two packs per day for half a year)
   p) Newborn congenital hypothyroidism screening
   q) Newborn hearing loss screening
   r) Newborn metabolic/hemoglobin screening
   s) Newborn sickle cell disease screening
   t) Newborn Phenylketonuria screening
   u) Obesity screening
   v) Osteoporosis screening
   w) Rh (d) incompatibility screening for pregnant women
   x) Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis and HIV screening
   y) Type 2 diabetes mellitus screening
   z) Tuberculin (TB)Testing
   aa) Urinary incontinence screening in women
   bb) Visual impairment in children screening

3. Health Promotion:
   a) Unhealthy alcohol use and drug misuse screening or assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse.
   b) Healthy diet behavioral counseling
   c) Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
   d) Sexually transmitted infections counseling.
   e) Tobacco use screening, tobacco use and tobacco-caused disease counseling and interventions. Including behavioral interventions. FDA-approved tobacco cessation prescription medications prescribed by a licensed health care professional authorized to prescribe drugs are also covered for women who are not pregnant and men. **NOTE**: There are resources available to You under the Colorado Quit Line. Please call 1-800-QUIT-NOW or visit its website at https://www.coquitline.org for more information.
   f) Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
   g) Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women, over age 35 with an increased risk of breast cancer and no history of breast cancer, risk reducing medication such as tamoxifen and raloxifene.
   h) When prescribed by a licensed health care professional authorized to prescribe drugs:
      i) Aspirin in the prevention of cardiovascular disease, colorectal cancer and preeclampsia in pregnant women.
      ii) Iron supplementation for children from 6 months to 12 months of age.
      iii) Oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
      iv) Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for prevention of dental caries in children
      v) Folic acid supplementation for women planning or capable of pregnancy.
   i) Interventions to promote breastfeeding: interventions during pregnancy and counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the postpartum period and the purchase of a breast pump. A hospital-grade electric breast pump, including any equipment that is required for pump functionality, is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
   j) All prescribed FDA-approved methods of contraception for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives and patches. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects; counseling for continued adherence, device removal, patient education and counseling. Over the counter FDA-approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs. The benefit will be provided as follows:
      i) For a three-month period the first time the prescription contraceptive is dispensed; and
      ii) For a twelve-month period or through the end of Your coverage whichever is shorter for any subsequent dispensing of the same prescription contraceptive regardless of whether You were enrolled in the plan at the time the prescription coverage was dispensed.
      iii) For a three-month period for a prescribed vaginal contraceptive ring.
      In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method.
   k) Screening and counseling for interpersonal and domestic violence.
   l) Physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
   m) Counseling of parents of young children, children, adolescents, and young adults; from age 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer.

n) Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

4. Disease prevention:
   a) Immunizations as recommended by the Centers for Disease Control and HRSA including the cervical cancer vaccine as required under state law.
   b) Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum
   c) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met:
      i) individuals are aged 40-75 years;
      ii) they have 1 or more cardiovascular risk factors; and
      iii) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.
   d) Pre-exposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to persons who are at high risk of HIV acquisition effective July 1, 2020.

Preventive services may change upon Policy renewal according to federal guidelines in effect as of January 1 of each year in the calendar year in which this Group Policy renews. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services. For a complete list of current preventive services required under the Patient Protection Affordable Care Act please call: 1-800-464-4000. You may also visit: www.healthcare.gov/center/regulations/prevention.html. Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

Note: The following services are not Covered Services under this Preventive Exams and Services benefit but may be Covered Services elsewhere in this **BENEFITS/COVERAGE (What is Covered)** section:
- Lab, Imaging and other ancillary services associated with prenatal care not inclusive to routine prenatal care
- Non-routine prenatal care visits
- Non-preventive services performed in conjunction with a sterilization
- Lab, Imaging and other ancillary services associated with sterilizations
- Treatment for complications that arise after a sterilization procedure

5. Exclusions for Preventive Care
   a) Personal and convenience supplies associated with breast-feeding equipment, such as pads, bottles, and carrier cases;
   b) Replacement or upgrades of purchased breast-feeding equipment.

6. Other Preventive Care
   a) Adult physical exam.
   b) Annual Mental Wellness check-up.
   c) Prostate Screening as follows when performed by a qualified medical professional, including but not limited to a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or Physician assistant:
      i) For men age forty (40) through age forty-nine (49), one screening per Accumulation Period if the Covered Person's Physician determines he is at high risk of developing prostate cancer; and
      ii) For men age fifty (50) and older, one screening per Accumulation Period.
      A prostate screening test consists of a prostate-specific antigen ("PSA") blood test and a digital rectal examination. Benefits are limited to a maximum payment of the lesser of the actual charge or $65 per screening and are exempt from any Deductibles.
   d) Colorectal screening services are covered for:
      i) Asymptomatic average-risk adults, who are 50 years of age or older; and
      ii) Covered Persons, who are at high risk for colorectal cancer. Such high-risk Covered Persons include those individuals who have:
         (1) A family medical history of colorectal cancer;
         (2) A prior occurrence of cancer or precursor neo-plastic polyps;
         (3) A prior occurrence of a chronic digestive disease condition, such as inflammatory bowel

disease, Crohn's disease, or ulcerative colitis, or other predisposing factors, as determined by a duly authorized provider.

(4) Benefits are provided for tests, as determined by a duly authorized provider that detect adenomatous polyps or colorectal cancer consistent with modalities that are included in "A" Recommendation or a "B" Recommendation of the Task Force.

e) Fecal DNA screening

f) Family planning services:
   i) Voluntary termination of pregnancy
   ii) Vasectomies

g) FDA-approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs for women who are pregnant.

h) Iron deficiency anemia screening for pregnant women

i) Expanded coverage of breast cancer screening services which includes:
   (1) The use of non-invasive imaging modality as recommended by the provider and within the appropriate use guidelines as determined by determined by the American College of Radiology and the National Comprehensive Cancer Network, for all individuals possessing at least one (1) risk factor for breast cancer including:
      (i) A family history of breast cancer;
      (ii) Being 40 years of age or older; or
      (iii) An increased lifetime risk of breast cancer determined by a risk factor model such as tyrer-cuzick, BRCAPRO, or GAIL by or other clinically appropriate risk assessment models.
   (2) Diagnostic imaging for further evaluation or supplemental imaging within the same policy year based on factors including a high lifetime risk for breast cancer or high breast density when deemed appropriate by the provider and the appropriate use guidelines as determined by determined by the American College of Radiology and the National Comprehensive Cancer Network.

j) The following services and items are covered as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
   (1) Hemoglobin A1C testing for individuals diagnosed with diabetes.
   (2) Retinopathy Screening for individuals diagnosed with diabetes.
   (3) Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
   (4) International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
   (5) Durable Medical Equipment items:
      (i) Peak flow meters for individuals diagnosed with asthma.
      (ii) Glucometers including lancets, strips, control solution and batteries for individuals diagnosed with diabetes.

Reconstructive Services

1. Reconstructive surgery including reconstruction of both the diseased and non-diseased breast after mastectomy to produce symmetrical appearance; and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
2. Treatment of Covered Persons, without regard to age, born with cleft lip and/or cleft palate, including the following procedures when found to be Medically Necessary: oral and facial surgery; surgical management and follow-up care by plastic surgeons and oral surgeons;
3. Treatment necessary for congenital hemangiomas and port wine stains.

Rehabilitation and Habilitation Services

1. Physical therapy to restore, keep, learn or improve skills or functioning. Therapy must be provided as prescribed by the attending Physician.
2. Speech therapy to restore, keep, learn or improve skills or functioning. This includes speech and language therapy and audiologic assessments and treatments for cleft lip and cleft palate.
3. Occupational therapy to restore, keep, learn or improve skills or functioning. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily

living. Therapy must be provided as prescribed by the attending Physician.
4. Multidisciplinary rehabilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program to restore, keep, learn or improve skills or functioning.
5. Pulmonary therapy to restore respiratory function after an illness or injury.
6. Cardiac Rehabilitation.

Skilled Nursing Facility Care
Room and Board and other services rendered in a Skilled Nursing Facility. Care must follow a Hospital Confinement, and the Skilled Nursing Facility confinement must be the result of an Injury or Sickness that was the cause of the Hospital Confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved, and no further significant measurable improvement can be anticipated.

Substance Use Disorder Services
1. Inpatient services including services in a Residential Treatment facility and medical management of withdrawal symptoms in connection with Substance Use Disorder. Medical Services for alcohol and drug Detoxification are covered in the same way as for other medical conditions.
2. Outpatient treatment services including court-ordered services,or supplies otherwise covered under the Group Policy if received in connection with Substance Use Disorder. Treatment is limited to a program of therapy in:
    a) A facility established primarily for the treatment of Substance Use Disorder; or
    b) A part of a Hospital used primarily for such treatment; or
    c) Any public or private facility providing services for the treatment of Substance Use Disorder, which is licensed by the Department of Health; or
    d) Any mental health facility approved by the Department of Institutions.

Transgender Surgery Services:
Medically necessary surgery to treat gender dysphoria limited to genital surgery, mastectomy, tracheal shave and facial hair removal, is covered. Benefits for Covered Services, which are associated with transgender surgery are provided in the same manner as any other medical or surgical coverage, as set forth under this Certificate.

Transplant Services
Transplant services in connection with an organ or tissue transplant procedure, including charges incurred by a donor or prospective donor who is not insured under this Group Policy. Covered Charges will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. The Group policy will not cover any donor expenses, if the donor has coverage elsewhere that covers donor expenses.

Urgent Care Services
Treatment in an Urgent Care Center. Urgent Care services are covered under the HMO In-Network benefit level described in the Health Plan Evidence of Coverage issued to you separately.

Vision Services
Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services.

Routine eye exams and refractive eye tests to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses.

All vision services not listed above are not covered, including but not limited to:
1. Laser Vision Correction
2. Orthoptics
3. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
4. Lenses, frames or contacts or their replacements.
5. Contact lens modification, polishing and cleaning.

6. Optical Hardware
7. Low vision aids

X-ray, Laboratory and Special Procedures

1. Diagnostic X-ray, pathology services and laboratory tests, Services and materials, including isotopes.
2. Diagnostic mammograms.
3. Electrocardiograms, electroencephalograms and mammograms.
   a) Therapeutic X-ray Services and materials including radiation therapy. Radiation treatment is limited to:
   b) X-ray therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or
4. the use of isotopes, radium or radon for diagnosis or treatment.
5. Special procedures such as MRI, CT, PET and nuclear medicine.

COVID-19 Services

Testing, treatment and other services that are related to COVID 19 to the extent required by applicable federal and state laws, regulations and bulletins.

LIMITATIONS/EXCLUSIONS (What is Not Covered)

No payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following, unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate, or in the **SCHEDULE OF BENEFITS (Who Pays What)** section, or any Rider or Endorsement that may be attached to the Group Policy. Refer to the **DEFINITIONS** section for the meaning of capitalized terms.

1. Charges in excess of the Maximum Allowable Charge.
2. Charges for non-Emergency Care in an Emergency Care setting.
3. Non-Emergency services outside the United States
4. Weekend admission charges for non-Emergency Care Hospital services except when surgery is performed on the day of admission or the next day. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Confinement, treatment, services or supplies which are not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the Group Policy.
6. Confinement, treatment, services or supplies not prescribed, authorized or directed by a Physician or that are received while not under the care of a Physician.
7. Injury or Sickness for which the Covered Person has or had a right to payment under worker's compensation or similar law.
8. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third-party coverage.
9. Injury or Sickness arising out of, or in the course of, past or current work for pay, profit or gain, unless workers' compensation or benefits under similar law are not required or available.
10. Injury or Sickness contracted while on duty with any military, naval, or air force of any country or international organization.
11. Treatment, services, or supplies provided by: (a) the Covered Person; (b) the Covered Person's spouse, partner in a civil union or Domestic Partner; (c) a child, sibling, or parent of the Covered Person or of the Covered Person's spouse, partner in a civil union or Domestic Partner; or (d) a person who resides in the Covered Person's home.
12. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: (a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or (b) payment is required by law.
13. Dental care and dental X-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, including surgery on the jawbone and radiation treatment, except as provided for covered dependent children under the Hospitalization and Anesthesia for Dental Procedures provision and Medically necessary orthodontia for the treatment of cleft lip and palate.
14. Cosmetic Surgery, plastic surgery, or other services that are indicated primarily to improve the Covered Person's appearance and will not result in significant improvement in physical function. This exclusion does not apply to services that: (a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; (b) are incidental to a covered mastectomy; or (c) are necessary for treatment of congenital hemangioma and port wine stains.
15. Any drug, procedure or treatment for sexual dysfunction regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation.
16. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements even if prescribed or administered by a Physician.
17. Any treatment, procedure, drug, or equipment or device which KPIC determines to be experimental or investigational. This means that one of the following is applicable:
    a) The service is not recognized in accordance with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or used in testing or in other studies on human patients; or
    b) The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

    This exclusion will not apply to Clinical Trials covered in the **BENEFITS/COVERAGE (What is Covered)** section or to Routine Patient Care Costs related to clinical trials if the Covered Person's

treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has the potential to provide a therapeutic health benefit to the Covered Person.

18. Special education and related counseling or therapy, or care for learning deficiencies or behavioral problems. This applies whether or not the services are associated with manifest Mental Health disorder or other disturbances.
19. Services or supplies rendered for the treatment of obesity; however, Covered Charges made to diagnose the causes of obesity or charges made for treatment of diseases causing obesity or resulting from obesity are covered.
20. Confinement, treatment, services or supplies that are required:
    (a) Only for insurance, travel, employment, school, camp, government licensing, or similar purposes; or
    (b) Only by a court of law except when medically necessary and otherwise covered under the plan.
21. Personal comfort items such as telephones, radios, televisions, or grooming services.
22. Custodial care. Custodial care is: (a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or (b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
23. Intermediate care. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.
24. Routine foot care such as trimming of corns and calluses.
25. Confinement or treatment that is not completed in accordance with the attending Physician's orders.
26. Hearing Therapy except where Medically Necessary to treat cleft lip and cleft palate.
27. Hearing aids for adults age 18 and over.
28. Services of a private-duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility.
29. Outpatient private duty nursing services.
30. Acupuncture; biofeedback; massage therapy; or hypnotherapy.
31. Health education, including but not limited to: (a) stress reduction; (b) weight reduction; or (c) the services of a dietitian.
32. Medical social services except those services related to discharge planning in connection with: (a) a covered Hospital Confinement; (b) covered Home Health Agency Services; or (c) covered Hospice Care.
33. Living expenses or transportation, except as provided for under Covered Services.
34. Second surgical opinions, unless required under the Medical Review Program.
35. Eye refractions, orthoptics, contact lenses, or the fitting of glasses or contact lenses; radial keratotomy or any other surgical procedures to treat a refractive error of the eye, except as specified in the **BENEFITS/COVERAGE (What is Covered)** section for Vision services.
36. Reversal of sterilization.
37. Services provided in the home other than Covered Services provided through a Home Health Agency or related to Hospice Care services, as set forth under the **BENEFITS/COVERAGE (What is Covered)** section.
38. Repair or replacement of Prosthetics resulting from misuse or loss.
39. Treatment for infertility not otherwise covered in the **BENEFITS/COVERAGE (What is Covered**) and **SCHEDULE OF BENEFITS (Who Pays What)** sections. Services not covered include: all Services and supplies related to conception by artificial means including but not limited to prescription drugs related to such Services, artificial insemination, in vitro fertilization, ovum transplants, gamete intrafallopian transfer and zygote intrafallopian transfer, donor semen, donor eggs and Services related to their procurement and storage. These exclusions apply to fertile as well as infertile individuals or couples.
40. Maintenance therapy for rehabilitation.
41. Travel immunizations.
42. Non-human and artificial organs and their implantation.
43. Surrogate pregnancy and services in connection with a Surrogacy Arrangement if the surrogate mother is not a Covered Person. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. For Covered Persons in a Surrogacy Arrangement please refer to "Surrogacy arrangements" under the

LIMITATIONS/EXCLUSIONS (What is Not Covered)

GENERAL POLICY PROVISIONS section for information about your obligations to Us in connection with a Surrogacy Arrangement, including Your obligations to reimburse Us for any Covered Services We cover and to provide information about anyone who may be financially responsible for Covered Services the baby (or babies) receive.

NOTE: This plan does not impose any Pre-existing condition exclusion.

MEMBER PAYMENT RESPONSIBILITY

Deductible
Before any benefits will be payable during the Accumulation Period, a Covered Person must first satisfy the Deductible shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. Unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section, the Deductible applies to all Covered Services. The Deductible will apply to each Covered Person separately and must be met within each Accumulation Period. When Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person.

Payments under the Group Policy are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of Deductible and Coinsurance amounts and for Covered Services received from a Non-Participating Provider any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the **DEFINITIONS** section.)

Covered Charges applied to satisfy any Deductibles under this Group Policy count toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. Covered Charges applied to satisfy any Deductibles under this Group Policy do not count toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier.

Self-Only Deductible
For a self-only enrollment (family of one Covered Person), there is only one Deductible known as Self-Only Deductible. When the Covered Person reaches his or her Self-Only Deductible, he or she will begin paying Copayment or Coinsurance.

Individual Deductible
For family enrollment (family of two or more Covered Persons), there is a Deductible for each individual family member known as Individual Deductible. Unless otherwise indicated in **the SCHEDULE OF BENEFITS (Who Pays What)** section or elsewhere in the Policy, the Accumulation Period Deductible as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section applies to all Covered Charges incurred by a Covered Person during an Accumulation Period. The Deductible applies separately to each Covered Person during each Accumulation Period. When Covered Charges equal to the Deductible are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. Benefits will not be payable for Covered Charges applied to the Deductible.

Family Deductible Maximum
The Deductible for a family has been satisfied for an Accumulation Period when a total of Covered Charges, shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section, has been applied toward the family members' Individual Deductibles.

If the Family Deductible Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section is satisfied in any one Accumulation Period by persons in covered family members, then the Individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Accumulation Period by any other person in Your family.

Benefit-specific deductibles
Some Covered Services are subject to additional or separate deductible amounts as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. These additional or separate deductibles do not contribute towards satisfaction of the Self-Only or Individual or Family Deductible.

NOTE: Please refer to the **SCHEDULE OF BENEFITS (Who Pays What)** section for the actual amount of Your Self-Only, Individual and Family Deductible.

MEMBER PAYMENT RESPONSIBILITY

Copayment/Coinsurance
You must pay any Copayment, Coinsurance as well as Deductibles for Covered Services. These Cost Shares are paid directly to the provider or facility. Copayment, Coinsurance and Deductible amounts are listed in **SCHEDULE OF BENEFITS (Who Pays What)** section. If You receive Covered Services from a Non-Participating Provider not chosen by You while at a Participating Provider facility, You are liable only for the Participating Provider Cost Share for the Covered Services You receive. In this circumstance, You are not liable for the difference between the Participating Provider Cost Share and the Non-Participating Provider's billed charges. If you receive a bill from a Non-Participating Provider in the circumstances described above, please call **Customer Service** at 1-855-364-3184 for assistance.

Out-of-Pocket Maximums
Any part of a charge that does not qualify as a Covered Charge, will not be applied toward satisfaction of the Out-of-Pocket Maximum.

Covered Charges applied to satisfy any Deductible under this Group Policy count toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. Covered Charges applied to satisfy any Deductible under this Group Policy do not count toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier.

Copayments and Coinsurance for Essential Health Benefits contribute toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. Coinsurance for Essential Health Benefits contribute toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier. Unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section. Copayment amounts and pharmacy cost shares do not accumulate to the Out-of-Pocket Maximum at the Non-Participating Provider Tier.

Charges in excess of the Maximum Allowable Charge or Benefit Maximum and additional expenses a Covered Person must pay because Pre-certification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

Self-Only Out-of-Pocket Maximum
For a self-only enrollment (family of one Covered Person), there is only one Out-of-Pocket Maximum known as Self-Only Out-of-Pocket Maximum. When the Covered Person reaches his or her Self-Only Out-of-Pocket Maximum, he or she no longer pays Copayments or Coinsurance for those covered services that apply towards the Out-of-Pocket Maximum for the rest of the Accumulation Period.

Individual Out-of-Pocket Maximums: When the Covered Person's Cost Share equals the Out-of-Pocket Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section during an Accumulation Period, the Percentage Payable will increase to 100% of further Covered Charges incurred by that same Covered Person for the remainder of that Accumulation Period.

Family Out-of-Pocket Maximums: When the family's Cost Share equals the Out-of-Pocket Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section during an Accumulation Period, the Percentage Payable will increase to 100% of further Covered Charges incurred by all family members for the remainder of that Accumulation Period.

NOTE: Please refer to the **SCHEDULE OF BENEFITS (Who Pays What)** section for the actual amount of Your Self-Only, Individual and Family Out-of-Pocket Maximum.

Deductible and Out-of-Pocket Maximum Takeover Credit
Any Expenses Incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of Deductibles and Out-of-Pocket Maximums, as applicable, under the Group Policy if:
1. The expenses were incurred during the 90 days before the Effective Date of the Group Policy;
2. The expenses were applied toward satisfaction of the deductibles or Out-of-Pocket Maximum under the Prior Coverage during the 90 days before the Effective Date of the Group Policy; and
3. The expenses would be considered Covered Charges under the Group Policy.

MEMBER PAYMENT RESPONSIBILITY

For Group Policies with effective dates of coverage during the months of April through December, Expenses Incurred from January 1 of the current year through the effective date of coverage with KPIC may be eligible for credit.

For Group Policies with effective dates of coverage during the months of January through March, Expenses Incurred up to ninety (90) days prior to the effective date with KPIC may be eligible for credit.

You must submit all claims for the Deductible and Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with KPIC.

Prior Coverage means the Policyholder's group medical plan that the Group Policy replaced. KPIC will insure any eligible person under the Group Policy on its Effective Date, subject to the above provisions which apply only to Covered Persons who on the day before the Group Policy's Effective Date were covered under the Prior Coverage.

Maximum Allowable Charge
Payments under the Plan are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service from a Non-Participating Provider. (Refer to the definition of Maximum Allowable Charge shown in the **DEFINITIONS** section of the Certificate.)

Other Maximums
To the extent allowed by law, certain treatments, services and supplies are subject to internal limits or maximums. These additional items are shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section**.**

NOTE: Please refer also to the **SCHEDULE OF BENEFITS (Who Pays What)** section at the beginning of this Certificate of Insurance.

CLAIMS PROCEDURE (How to File a Claim)

All claims under the Group Policy will be administered by:

National Claims Administration – Colorado .
PO Box 373150
Denver, CO 80237-9998
1-855-364-3184 (Toll-free)
711 (TTY)

Questions about Claims
For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call the number shown above, or You may write to the address shown above. Claim forms are available from Your employer.

You need to pay only Your Deductible and Coinsurance or Copayment.

Claim Filing Requirements
Set forth below is a description of Our claim filing requirements. You may also request a separate copy of Our claim filing requirements by writing to Us. We will respond to such requests within fifteen (15) calendar days. If We change any of the requirements, We will provide You with a copy of the revised requirements within fifteen (15) calendar days of the revision.

Claim Forms
We will provide the claimant with the notice of claim form. You must give Us written notice of claim within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon as reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. The notice should be mailed to Us at Our mailing address or to Our Claims Administrator at the address provided above.

When We receive Your notice of claim, We will send You forms for filing Proof of Loss. The forms may be obtained from and must be filed with KPIC's Administrator's office at the address set forth above. If We do not send You these forms within fifteen (15) days after receipt of Your Notice of Claim, You shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, the within the time limit stated in the Proof of Loss section. Clean Claims, as defined, will be paid, denied or settled within thirty (30) calendar days after receipt if submitted electronically, or within forty-five (45) calendar days, if the claim is submitted by any other means. If a claim is denied in whole or in part, the written notice of denial will contain: (1) reasons for the denial; (2) reference to the pertinent provisions of the Group Policy on which the denial is based; and (3) information concerning the Covered Person's right of appeal.

If additional information is required to complete the processing of Your Claim, We will request such information within thirty (30) calendar days after receiving Your Claim. We will provide a full explanation in writing as to what additional information is needed to resolve the claim from Your group or health care provider, or You. The person or entity receiving the request for additional information must submit all additional information to Us within thirty (30) calendar days after receiving the request. Under applicable Colorado law, We may deny a claim if You and/or the provider fail to submit the requested additional information in a timely manner. Absent fraud, all claims, except those considered to be Clean Claims, shall be paid, denied, or settled within ninety (90) calendar days after receipt by KPIC.

If the Covered Person is dissatisfied with the results of a review, the Covered Person may request a reconsideration. The request must be in writing and filed with KPIC's Administrator at the address set forth above. The written request for reconsideration must be filed within thirty (30) days after the notice of denial is received. A written decision on reconsideration will be issued within thirty (30) days after KPIC's Administrator receives the request for reconsideration.

CLAIMS PROCEDURE (How to File a Claim)

Proof of Loss
Written Proof of Loss must be sent to Us or to Our Administrator at the address shown on the preceding page within ninety (90) days after the day services were received. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, but in no event, later than one year from the time proof is otherwise required, except in the absence of legal capacity. If You receive services from a Participating Provider, that provider will normally file the claim on Your behalf. At Your option, You may direct, in writing to KPIC, that benefits be paid directly to the provider.

Payment of Benefits
Benefits will be payable to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof of loss. The Covered Person, at his or her option, may assign, in writing to KPIC, all or part of such benefits directly to a person or institution on whose charges a claim is based.

A Covered Person may also authorize KPIC to pay benefits directly to a person or institution on whose charges a claim is based. Any such payments will discharge KPIC to the extent of payment made. Unless allowed by law, KPIC's payments may not be attached, nor be subject to, a Covered Person's debts.

At the Covered Person's option, any benefits for health expenses for covered medical transportation services may be assigned, in writing to KPIC, to the provider of these services. No benefits are payable to the Covered Person to the extent benefits for the same expenses are paid to the provider.

KPIC shall not retroactively adjust a claim based on eligibility if:
(1) The provider received verification of eligibility within two (2) business days prior to delivery of services unless the Policyholder notified KPIC:
    (a) That Employee is no longer eligible;
    (b) That Policyholder no longer intends to maintain coverage for the Group;
    (c) Within ten (10) business days after the date that Employee is no longer eligible or covered because the employee left employment without notice to the Policyholder/Employer or employment was terminated because of gross misconduct
(2) The provision of benefit is a required policy provision pursuant to state law unless the Policyholder notified KPIC of Employee's ineligibility within the timeframe provided in (1) (c).

Reimbursement of Providers
Reimbursement for services covered under this health insurance plan which are lawfully performed by a person licensed by the State of Colorado for the practice of osteopathy, medicine, dentistry, optometry, psychology, chiropractic, or podiatry shall not be denied when such services are rendered by a person so licensed. Licensed persons shall include registered professional nurses and licensed Clinical Social Workers within the scope of professional nursing or licensed social worker practice.

Legal Actions
No action at law or in equity may be brought to recover under the Group Policy prior to the expiration of sixty (60) days after the claim has been filed as required by the Group Policy. Also, no action may be brought after three (3) years from the expiration of the time within which proof of loss is required by the Group Policy.

Time Limitations
If any time limitation provided in the Group Policy for giving notice of claims, or for bringing any action at law or in equity, is less than that permitted by the applicable law, the time limitation provided in the Group Policy is extended to agree with the minimum permitted by the applicable law.

Assignment of Benefits to Colorado Department of Social Services
If a Covered Person receives medical assistance from the State of Colorado, under Colorado law, the State is deemed to have an assignment on all benefit payments made for medical expenses on behalf of the Covered Person or any other covered family member. The assignment remains in effect as long as

the individual is eligible for and receives medical assistance benefits from the State. This means that KPIC may pay benefits directly to the State when KPIC is aware that the Covered Person is a medical assistance recipient. Any payments made by KPIC in good faith pursuant to the State's assignment will fully discharge KPIC's obligation to the extent of the payment.

NOTE: For general information on claims, and how to submit Pre-Service Claims, Concurrent Care Claims, and Post-Service Claims, see the **APPEALS AND COMPLAINTS** section. For covered Services by Non-Participating Providers, you may need to submit a claim on your own. Contact **Customer Service** for more information on how to submit such claims.

GENERAL POLICY PROVISIONS

Time Effective
The effective time for any dates used is 12:01 a.m. at the address of the Policyholder.

Incontestability
Any statement made by the Policyholder or a Covered Person in applying for insurance under this Policy will be considered a representation and not a warranty. Its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement as determined by a court of competent jurisdiction. Only statements that are in writing and signed by the Policyholder and/or Covered Person may be used in a contest.

This Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue and that no statement made for the purpose of effecting insurance coverage under the policy with respect to a person shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits under such policy after such insurance has been in force for a period of two years during the lifetime of the Covered Person unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to the person making the statement or to the beneficiary of any such person.

Misstatement of Age
If the age of any person insured under this health insurance plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

Medical Examination and Autopsy
KPIC, at its own expense, shall have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Money Payable
All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

Rights of a Custodial Parent
If the parents of a covered Dependent child are:
1. Divorced or legally separated; and
2. Subject to the same Order,

The custodial parent will have the rights stated below without the approval of the non-custodial parent. However, for this provision to apply, the non-custodial parent must be a Covered Person approved for family health coverage under the Policy, and KPIC must receive:
1. A request from the custodial parent, who is not a Covered Person under the policy; and
2. A copy of the Order.

If all of these conditions have been met, KPIC will:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the Policy;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until We determine that:
1. The Order is no longer valid;
2. The Dependent child has become covered under other health insurance or health coverage;
3. In the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
4. The Dependent child is no longer a Covered Person under the Policy.

Termination by KPIC
KPIC may terminate the Group Policy or any insurance under the Group Policy on any premium due date by giving no less than 31 days written notice when the Policyholder:
1. Fails to pay premiums or contributions in accordance with the plan provisions, or KPIC does not receive premium payments in a timely manner; or
2. Commits an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the Group Policy; or
3. Fails to comply with a material health benefit plan contract provision, including contribution or group participation rules; or
4. No longer has any Covered Persons living, residing or working in the service area of the Preferred Provider Organization with respect to a Group Policy providing coverage, in whole or in part, in connection with a Preferred Provider plan.

If KPIC decides to discontinue offering this particular health benefit plan in the group market, KPIC may discontinue all coverage under the Group Policy. KPIC will give written notice of this type of nonrenewal to each Policyholder 90 days before the date coverage terminates. KPIC will offer each Policyholder whose coverage is discontinued the option to purchase another group health benefits plan currently offered by KPIC in the applicable state without regard to any health status-related factor of any Covered Person, including any individuals who may become eligible for the replacement coverage. Health benefit plan under this section means a particular product and not a plan design.

If KPIC stops offering all health insurance coverage in the group market, in the applicable state, KPIC has the right not to renew all policies issued on this form. KPIC will give written notice of this type of nonrenewal to the Policyholders and all Covered Persons 180 days before the date coverage terminates. Notice to an Insured Employee will be deemed notice to the Insured Dependents of that Insured Employee.

The Policyholder will be liable for all unpaid premiums for the period during which the Group Policy was in force with respect to any Covered Person whose coverage terminates.

Completion of Covered Services by a Terminated Provider – For PPO Plans only
If You are inpatient in a Hospital, Skilled Nursing Facility, or a hospice for Hospice Care at the time of a Participating Provider's termination, You will continue to receive coverage for Covered Services until Your date of discharge from such inpatient facility consistent with applicable Colorado law.

As to services other than inpatient services, We will advise You in writing as to the specific extension of time, under Colorado law, pertaining to the rendition of Covered Services by a terminated Participating Provider

Coordination of Benefits Provisions Application
This Coordination of Benefits ("COB") provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order-of-benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

GENERAL POLICY PROVISIONS

Definitions Related to Coordination of Benefits

A. A "**plan"** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1. "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   2. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non- medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The **order-of-benefit payment rules** determine whether this plan is a "Primary plan" or "Secondary plan" when compared to another plan covering the person.

   When this plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable Expense** is a health care service or expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service or portion of an expense that is not covered by any of the Plans covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:
   1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
   2. If a Covered Person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   4. If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable Expense for all

Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Claim determination period** is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

F. **Closed Panel Plan** is a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-of-Benefit Payment Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. (1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always Primary unless the provisions of both plans state that the complying plan is Primary.
(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering the Covered Person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an employee, member, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary plan;

or

ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the custodial parent;
- The Plan covering the spouse of the custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Covered Person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a Covered Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

A. When this Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence

of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. The claims administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The claims administrator need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under this Plan must give the claims administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, the claims administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The claims administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by the claims administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Surrogacy arrangements
If You enter into a Surrogacy Arrangement and You or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, You must reimburse Us for covered Services You receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") except that we will recover no more than half of the monetary compensation you receive. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" provision does not affect Your obligation to pay Your Cost Share for these Covered Services. After You surrender the baby to the legal parents, You are not obligated to reimburse Us for any Covered Services that the baby receives after the date of surrender (the legal parents are financially responsible for any Covered Services that the baby receives).

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, You must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian
Kaiser Permanente
Surrogacy Mailbox
P.O. Box 36380
Louisville KY 40233

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy arrangements" section without our prior, written consent.

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

If You have questions about Your obligations under this provision, please contact **Customer Service** at 1-855-364-3184.

TERMINATION/NON-RENEWAL/CONTINUATION

Termination of an Insured Employee's Insurance
Except as provided in the Continuation of Medical Benefits provision, Your insurance will automatically terminate on the earlier of:

1. The date the employee or employee's Dependents cease to be covered by Health Plan as a Point of Service member;
2. The date the Group Policy is terminated;
3. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. The end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion; or
5. The last day of the month You cease to qualify as an Eligible Employee.

In no event will Your insurance continue beyond the earlier of the date Your employer is no longer a Policyholder and the date the Group Policy terminates. The Health Plan Evidence of Coverage more fully explains the eligibility, effective date, and termination provisions.

Termination of Insured Dependent Coverage
An Insured Dependent's coverage will end on the earlier of:

1. The date You cease to be covered by KPIC;
2. The last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. The date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;
4. The end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
5. The date the Group Policy is terminated;
6. The date the Dependent, or the Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
7. The date the Dependent relocates to a place outside of the geographic service area of a provider network, if applicable, unless specifically provided otherwise in the Group Policy.

Medically Necessary Leave of Absence for Student Dependent
If You, as a Dependent, are enrolled in a post-secondary educational institution, Your coverage will not terminate due to a Medically Necessary Leave of Absence before the date that is the earlier of: (a) one year after the first day of the Medically Necessary Leave of Absence or (b) the date coverage would otherwise terminate under the terms of the Group Policy.

Continuation of Coverage during Layoff or Leave of Absence
If Your full-time work ends because of a disability, an approved leave of absence or layoff, You may be eligible to continue insurance for Yourself and Your Dependents up to a maximum of three months if full-time work ends because of disability or two months if work ends because of layoff or leave of absence other than family care leave of absence. These provisions apply as long as You continue to meet Your Group's written eligibility requirements and This health insurance plan has not terminated. You may be required to pay the full cost of the continued insurance during any such leave.

Rescission for Fraud or Intentional Misrepresentation
Subject to any applicable state or federal law, if KPIC makes a determination that You performed an act, practice or omission that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Group Policy, KPIC may rescind Your coverage under the Group Policy by giving You no less than thirty (31) days advance written notice. The rescission will be effective, on:

1. The effective date of Your coverage, if we relied upon such information to provide coverage; or
2. The date the act of fraud or intentional misrepresentation of a material fact occurred, if the fraud or intentional misrepresentation of a material fact was committed after the Effective Date of Your coverage.

If Your or Your Dependent's Policy is rescinded, you have the right to appeal the rescission. Please refer to the **APPEALS AND COMPLAINTS** section of this Certificate for a detailed discussion of the grievance and Appeals process and Your right to an Independent External Review.

CONTINUATION OF MEDICAL BENEFITS (FEDERAL)

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA).

Eligibility for Continued Health Coverage
A Covered Person whose group health coverage under the policy would end due to a qualifying event may have a right to elect continued Health Coverage for a limited period.

The phrase "health coverage" means the benefits of the policy that are based on Expenses Incurred for medical care.

A "Qualifying Event" is any one of the following events if it would cause the Covered Person to lose health coverage under the policy:
"A" The death of the covered employee;
"B" The termination (other than by reason of the covered employee's gross misconduct), or reduction in hours, of such employee's employment;
"C" The divorce or legal separation of the covered employee and his or her spouse, partner in a civil union or Domestic Partner;
"D" The covered employee's becoming entitled to Medicare benefits;
"E" A child's ceasing to be an eligible Dependent under the terms of this health insurance plan.

Written Notices and Election Required
Covered Persons must notify their employers of a qualifying event set forth in "C" or "E". That notice must be given within sixty (60) days after the event occurs. If such timely notice is not given, the event will not entitle the Covered Person to continued health coverage.

The employer will notify Covered Persons who become entitled to elect continued health coverage. That notice will be furnished within fourteen (14) days of: (a) the date timely notice of a qualifying event set forth in "C" or "E" is received; or (b) the date any other qualifying event occurs. If that notice from the employer is not given or is late, the qualifying event will not entitle the Covered Person to continued health coverage. Should a court or government agency require KPIC to pay any benefits as though coverage had been continued, the employer will reimburse KPIC in the full amount that KPIC is required to pay.

A Covered Person will have sixty (60) days in which to elect continued health coverage. That sixty (60) days starts with the later of: (a) the date the qualifying event would cause the Covered Person to lose health coverage under this health insurance plan; or (b) the date the employer provides timely notice to the Covered Person of his or her right to elect continued health coverage. A Covered Person who does not make a timely written election will not receive continued health coverage unless included as a spouse, partner in a civil union or Domestic Partner or child in another family member's timely election.

Effect of Other Continuations
If this health insurance plan otherwise provides any health coverage after a qualifying event: (a) such coverage that is not an option will not defer or extend the maximum period of continued health coverage in this provision; and (b) such coverage that is an elected option will be deemed a waiver of continued health coverage under this provision. However, if a covered employee elects such alternate health coverage for a spouse, partner in a civil union or Domestic Partner or child; and while that coverage is in effect another qualifying event occurs; then the alternate health coverage for the spouse, partner in a civil union or Domestic Partner or child will not end sooner than it would have under this provision.

Payment for Continued Health Coverage
The employer may require a Covered Person to pay for this continued health coverage. That payment will not exceed 102 percent of the total employer and employee cost of providing the same benefits to a Covered Person who has not had a qualifying event. The Covered Person will not be required to make

such payments less frequently than monthly.

Benefits under Continued Health Coverage
This continued health coverage will at all times provide the same health care benefits as would have been afforded to the Covered Person had a qualifying event not occurred. This includes any changes in the health coverage under this health insurance plan as may become effective while continued health coverage is in effect.

Termination of Continued Health Coverage
A Covered Person's continued health coverage under this provision will end at the earliest of the following dates:

1. The date which ends the "Maximum Period" as defined below;
2. The date that This Plan no longer covers the employer that sponsored the coverage before the Qualifying Event;
3. The date ending the last period for which the Covered Person has made any required payment for continued Health Coverage on a timely basis; or
4. The date after electing continued Health Coverage on which the Covered Person first becomes: a) covered under any other group health plan (as an employee or otherwise) which does not exclude or limit any pre-existing condition of the Covered Person; or b) entitled to Medicare benefits.

The "Maximum Period" referred to above will start with the date of the Qualifying Event and will end: (a) with the date eighteen (18) months after a qualifying event set forth in "B"; or (b) with the date thirty-six (36) months after any other Qualifying Event. In applying this maximum period, if continued health coverage is already in effect when a qualifying event other than as set forth in "B" occurs, the maximum period will not end less than thirty-six (36) months from the date of the original qualifying event; and if a Qualifying Event set forth in "D" occurs, the Maximum Period as to the Covered Employee's spouse, partner in a civil union or Domestic Partner or child for that or any subsequent Qualifying Event will not end less than thirty-six (36) months from the date the Covered Employee became entitled to Medicare benefits.

Extension for Disabled Covered Persons
If Social Security, under its rules, determines that a Covered Person was disabled when a Qualifying Event set forth in "B" occurred, the 18-month maximum period of continued health coverage for such a Qualifying Event may be extended to twenty-nine (29) months. To obtain that extension, the Covered Person must notify the employer of Social Security's determination before the initial 18-month maximum period ends.

For the continued health coverage of disabled Covered Persons that exceeds eighteen (18) months, KPIC may increase the premium it charges by as much as 50 percent. The employer may require the disabled Covered Persons to pay all or part of that total increased premium.

In no event will continued Health Coverage extend beyond the first month to begin more than thirty (30) days after Social Security determines that the Covered Person is no longer disabled. The Covered Person must notify the employer within thirty (30) days of the date of such a Social Security determination.

Continued Health Coverage from a Prior Plan
Continued Health Coverage will also be provided if: (a) this health insurance plan replaced a prior benefit plan of the employer or an associated company; and (b) a person's continued health coverage under a provision of that prior plan similar to this ended due to the replacement of that prior plan. In such case, that person may obtain continued Health Coverage under this provision. It will be as though this health insurance plan had been in effect when the Qualifying Event occurred. But no benefits will be paid under this health insurance plan for health care Expenses Incurred before its effective date.

TERMINATION/NON-RENEWAL/CONTINUATION

Continued Health Coverage under Uniformed Services Employment and Reemployment Rights Act (USERRA)
If You are called to active duty in the uniformed services, You may be able to continue Your coverage under this Policy for a limited time after You would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to Your Employer within 60 days after Your call to active duty.

Please contact Your Employer to find out how to elect USERRA coverage and how much You must pay Your Employer.

CONTINUATION OF MEDICAL BENEFITS (STATE)

Continuation of Health Coverage
A Covered Person must be given the option to elect continuation of this health insurance plan for himself or herself and any Dependents if:
1. The Covered Person's eligibility to receive coverage has ended for any reason other than discontinuance of the Group Policy in its entirety or with respect to an insured class;
2. Any premium or contribution required from or on behalf of the Covered Person has been paid to the termination date; and
3. The Covered Person has been continuously insured under the Group Policy, or under any Group Policy providing similar benefits which it replaces, for at least six (6) months immediately prior to termination.

A Covered Person has the right to continue coverage for: (a) a period of eighteen (18) months after termination of employment; or (b) until the Covered Person becomes re-employed, whichever occurs first. Should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen (18) months or until the new plan covers the condition, whichever occurs first.

The Covered Person must elect to continue coverage and pay the applicable amount to apply toward the premium within twenty (20) days after termination of employment. If proper notification is not given to the Covered Person, the Covered Person may elect to continue coverage and pay the applicable amount to apply toward the insurance within thirty (30) days after termination of employment.

Reduced Work Hours
The Policyholder may elect to contract with KPIC to continue coverage under the same conditions and for the same premium for Covered Person, even if the Policyholder reduces the working hours of such Covered Person to less than thirty (30) hours per week, provided the following conditions are met:
1. The Covered Person has been continuously employed as a full-time employee of the Policyholder and has been insured under the Group Policy or any Group Policy providing similar benefits which said policy replaces, for at least 6 months immediately prior to such reduction in working hours;
2. The Policyholder has imposed such reduction in working hours due to economic conditions; and
3. The Policyholder intends to restore the Covered Person to a full 40-hour work schedule as soon as economic conditions improve.

APPEALS AND COMPLAINTS

Claims and Appeals
KPIC will review claims and appeals, and We may use medical experts to help Us review them. The following terms have the following meanings when used in this "**APPEALS and COMPLAINTS**" section:

1. A **Claim** is a request for us to:
   a. Pay for a Service that You have not received (Pre-Service claim),
   b. Continue to pay for a Service that You are currently receiving (Concurrent Care Claim), or
   c. Pay for a Service that you have already received (Post-Service claim).

2. An **Adverse Benefit Determination** is Our decision to do any of the following:
   a. Deny Your Claim, in whole or in part, including:
      i) A denial, in whole or in part, of a Pre-Service Claim (preauthorization for a Service), a Concurrent Care Claim (continue to provide or pay for a Service that You are currently receiving) or a Post-Service Claim (a request to pay for a Service) in whole or in part; or
      ii) A denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or
      iii) A denial of a request for Services on the ground that the Service is experimental or investigational.
   b. Terminate Your coverage retroactively except as the result of non-payment of premiums (also known as Rescission or Retroactive Cancellation), or
   c. Uphold Our previous Adverse Benefit Determination when You appeal.

   In addition, when We deny a request for medical care because it is excluded under this policy and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then Our denial shall be considered an adverse benefit determination.

3. An **Appeal** is a request for Us to review Our initial Adverse Benefit Determination.

If You miss a deadline for making a Claim or Appeal, We may decline to review it.

Except when simultaneous External Review can occur, You must exhaust the Internal Claims and Appeals Procedure as described below in this **"APPEALS and COMPLAINTS"** section unless We fail to follow the claims and appeals process described in this Section.

Language and Translation Assistance
You may request language assistance with Your Claim and/or Appeal by calling **Member Services** at 1-800-632-9700 or 711 (TTY).

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-632-9700.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-800-632-9700.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-632-9700.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-9700.

Appointing a Representative
If You would like someone including your provider (medical facility or health care professional) to act on Your behalf regarding Your Claim, You may appoint an authorized or designated representative. You must make this appointment in writing. Please contact **Customer Service** at 1-855-364-3184 or 711 (TTY) for information about how to appoint a representative. You must pay the cost of anyone You hire to represent or help You.

APPEALS AND COMPLAINTS

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim

If You want to review the information that We have collected regarding Your Claim, You may request, and We will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling **Member Appeals Program** at 1-888-370-9858 or 1-303-344-7933 or 711 (TTY).

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact **Customer Service** at 1-855-364-3184 or 711 (TTY).

Providing Additional Information Regarding Your Claim and/or Appeal

When You appeal, You may send Us additional information including comments, documents, and additional medical records that You believe support Your Claim. If We asked for additional information and You did not provide it before We made Our initial decision about Your Claim, then You may still send Us the additional information so that We may include it as part of Our review of Your Appeal, if You ask for one. Please send all additional information to the Department that issued the Adverse Benefit Determination.

When You appeal, You may give testimony in writing or by telephone. Please send Your written testimony to **Member Appeals Program**. To arrange to give testimony by telephone, you should contact **Member Appeals Program a**t 1-888-370-9858 or 1-303-344-7933 or 711 (TTY).

We will add the information that You provide through testimony or other means to Your Claim file and We will review it without regard to whether this information was submitted and/or considered in Our initial decision regarding Your Claim.

Sharing Additional Information That We Collect

If We believe that Your Appeal of Our initial Adverse Benefit Determination will be denied, then before We issue Our next Adverse Benefit Determination We will also share with You any new or additional reasons for that decision. We will send You a letter explaining the new or additional information and/or reasons and inform You how You can respond to the information in the letter if You choose to do so. If You do not respond before We must make Our next decision, that decision will be based on the information already in Your Claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending Your Claim and Appeal to Us as described in this **APPEALS and COMPLAINTS** section:

1. Pre-Service Claims (Urgent and Non-Urgent)
2. Concurrent Care Claims (Urgent and Non-Urgent)
3. Post-Service Claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of coverage (rescission).

Your internal review process includes (a) one mandatory level of review which is the First Level Appeal and (b) a voluntary second level of review which is the Voluntary Second Level Appeal. The Voluntary Second Level Appeal may only occur at your option. If you disagree with our decision on your First Level Appeal, your adverse First Level Appeal decision notice will tell you how to submit a Voluntary Second Level Appeal.

When you file an appeal, We will review Your Claim without regard to our previous Adverse Benefit Determination. The individual who reviews Your Appeal will not have participated in Our original decision regarding Your Claim nor will he/she be the subordinate of someone who did participate in Our original decision.

1. Pre-Service Claims and Appeals
   Pre-service Claims are requests that We pay for a Service that You have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for Our denial of Your Pre-service Claim. If You receive any of the Services You are requesting before We make Our decision, Your Pre-service Claim or Appeal will become a Post-service Claim or Appeal with respect to those Services. If You have any general questions about Pre-service Claims or Appeals, please call **Customer Service** at 1-855-364-3184 or 711 (TTY).

   Here are the procedures for filing a Pre-service claim, a Non-Urgent Pre-service Appeal, and an Urgent Pre-service Appeal.

   a. Pre-Service Claim
      Tell KPIC in writing that You want Us to pay for a Service You have not yet received. Your request and any related documents You give us constitute Your Claim. You or Your Provider must either mail or fax Your Claim to:

      Permanente Advantage
      5855 Copley Drive, Suite 250
      San Diego, CA 92111
      1-888-525-1533 (office)
      1-866-338-0266 (fax)

      If You want Us to consider Your Pre-service Claim on an Urgent basis, the request should tell us that. We will decide whether Your Claim is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Claim is Urgent. If We determine that Your Claim is not Urgent, We will treat Your Claim as Non-Urgent. Generally, a Claim is Urgent only if using the procedure for Non-Urgent Claims: (a) Could seriously jeopardize Your life, health, or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an Expedited External Review.

      Non-Urgent Pre-Service Claim
      We will review Your Claim and, if We have all the information We need, We will make a decision within a reasonable period of time but not later than five (5) business days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, so long as We notify You and inform You and Your Provider prior to the expiration of the initial five (5) day period and explain the circumstances for which we need the extension.

      If We need more information, We will ask You and Your Provider for additional information within the initial five (5) business day decision period, and We will give You and Your Provider two (2) business days from receipt of Our request to send the additional information. We will make a decision within five (5) business days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive the additional information (including documents) from You or Your Provider within two (2) business days after receipt of Our request, We will make a decision based on the information We have.

We will send written notice of Our decision to You and if applicable to Your Provider.

Urgent Pre-Service Claim

If Your Pre-service Claim was considered on an Urgent basis and We have all the information We need, We will notify You and Your Provider of Our decision (whether adverse or not) orally or in writing within two (2) business days but not later than seventy-two (72) hours after We receive Your Claim. Within twenty-four (24) hours after We receive Your Claim, We may ask You and Your Provider for more information. We will give You and Your Provider within two (2) business days from receipt of Our request to send the additional information. We will notify You and Your Provider of Our decision within two (2) business days but not longer than forty-eight (48) hours of receiving the first piece of requested information. If We do not receive the additional information (including documents) from You or Your Provider within two (2) business days after receipt of Our request, We will make a decision based on the information We have and We will notify You of Our decision either orally or in writing. If We notify You of Our decision orally, We will send You and Your Provider written confirmation within three (3) days after that.

Your Pre-Service Claim shall be deemed to have been approved for failure on Our part to:

a) Request additional information needed to process the claim from You and Your Provider; or
b) Provide the notification of approval to You and Your Provider; or
c) Provide the notification of denial to You and Your Provider

within the required time frames set forth above.

Validity of Approval of a Pre-Service Claim

An approval of a Pre-Service Claim is valid for a period of one hundred eighty (180) days after the date of approval and continues for the duration of the authorized course of treatment. Once approved, We cannot retroactively deny a Pre-certification request for a treatment or service. This 180-day approval does not apply if:

a) The Pre-Service Claim approval was based on Fraud; or
b) The provider never performed the services that were requested; or
c) The service provided did not align with the service that was approved; or
d) The person receiving the service no longer had coverage under the plan on or before the date the service was delivered; or
e) The covered person’s benefit maximums were reached on or before the date the service was delivered.

If We deny Your Claim (if We do not agree to pay for all the Services You requested), Our Adverse Benefit Determination notice will tell You why We denied Your Claim and how You can appeal.

b. Non-Urgent Pre-Service First Level Appeal

Within one hundred eighty (180) days after You receive our Adverse Benefit Determination notice, You must tell us by either calling us or writing to us that You want to Appeal Our denial of Your Pre-service Claim. We will count the one hundred eighty (180) calendar starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period.

Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) the specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal.

For medical benefits other than Outpatient Prescription Drugs, You must either mail or fax Your Appeal to the **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

For Outpatient Prescription Drugs, You can appeal orally by calling 1-800-788-2949 (Pharmacy Help Desk) or in writing by mailing to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal (who was not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that five-(5) day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than thirty (30) days after we receive Your Appeal.

If we deny Your Appeal, our Adverse Benefit Determination notice will tell you why we denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

c. Urgent Pre-Service First Level Appeal

Tell us that You want to urgently appeal our Adverse Benefit Determination regarding your Pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal

For medical benefits other than Outpatient Prescription Drugs, You can appeal orally by calling **Customer Service** at 1-855-364-3184 or in writing by mailing or sending by fax to **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

For Outpatient Prescription Drugs, You can appeal orally by calling 1-800-788-2949 (Pharmacy Help Desk) or in writing by mailing to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131

When You send Your Appeal, You may also request simultaneous External Review of Our initial Adverse Benefit Determination. If You want simultaneous External Review, Your Appeal must tell Us this. You will be eligible for the simultaneous External Review only if Your Pre-service Appeal qualifies as Urgent. If You do not request simultaneous External Review in Your Appeal, then You may be able to request External Review after We make Our decision regarding Your Appeal (see "External Review" in this "**APPEALS and COMPLAINTS**" section), if Our internal Appeal decision is not in your favor.

We will decide whether Your Appeal is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Appeal is Urgent. If We determine that Your Appeal is not Urgent, We will treat Your Appeal as Non-Urgent. Generally, an Appeal is Urgent only if using the procedure for Non-Urgent Appeals (a) Could seriously jeopardize Your life, health, or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting. We may, but not required to waive the requirements related to an Urgent Appeal to permit you to pursue an Expedited External Review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review Your Appeal and give You oral or written notice of Our decision as soon as Your clinical condition requires, but not later than seventy-two (72) hours after We received Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

If We deny Your Appeal, our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

2. Concurrent Care Claims and Appeals.
Concurrent Care Claims are requests that KPIC continues to pay for an ongoing course of covered treatment or services for a period of time or number of treatments, when the course of treatment already being received will end. If You have any general questions about Concurrent Care Claims or Appeals, please call the **Customer Service** at 1-855-364-3184 or 711 (TTY).

Unless You are appealing an Urgent Concurrent Care Claim, if We either (a) Deny Your request to extend Your current authorized ongoing care (Your Concurrent Care Claim) or (b) Inform You that the authorized care that You are currently receiving is going to end early and You then appeal our decision (an Adverse Benefit Determination), then during the time that We are considering Your Appeal, You may continue to receive the authorized Services. If you continue to receive these Services while We consider Your Appeal and Your Appeal does not result in our approval of Your Concurrent Care Claim, then KPIC will only pay for the continuation of services until we notify you of our appeal decision

Here are the procedures for filing a Concurrent Care Claim, a Non-Urgent concurrent care appeal, and an Urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us by either calling us or writing to us that you want to make a Concurrent Care Claim for an ongoing course of covered treatment. Inform us in detail of the reasons that Your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute Your Claim. You must either mail or fax Your Claim to the **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

If You want us to consider Your Claim on an Urgent basis and You contact us at least twenty-four (24) hours before Your care ends, You may request that We review Your Concurrent Claim on an Urgent basis. We will decide whether Your Claim is Urgent or Non-urgent unless Your attending health care provider tells us Your Claim is Urgent. If We determine that Your Claim is not Urgent, We will treat Your Claim as Non-urgent. Generally, a Claim is Urgent only if using the procedure for Non-urgent Claims (a) Could seriously jeopardize Your life, health or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (b) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without extending Your course of covered treatment.. We may, but are not required to waive the requirements related to an urgent claim and appeal thereof to permit you to pursue an Expedited External Review.

We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim twenty-four (24) hours or more before Your care is ending, We will make our decision before Your authorized care actually ends (that is, within 24 hours of receipt of Your claim). If Your authorized care ended before You submitted Your Claim, We will make our decision within a reasonable period of time but no later than fifteen (15) days after we receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We send You notice before the initial fifteen-(15) day period ends and explain the circumstances and the reason for the extension and when we expect to make a decision.

If We tell You We need more information, We will ask You for the information before the initial decision period ends and We will give you until Your care is ending or, if Your care has ended, forty-five (45) days to send us the information. We will make our decision as soon as possible, if Your care has not ended, or within fifteen (15) days after We first receive any information (including documents) we requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate timeframe, not to exceed fifteen (15) days following the end of the forty-five (45) days that We gave you for sending the additional information.

We will send written notice of our decision to You and, if applicable to Your Provider, upon request. Please let Us know if You wish to have Our decision sent to Your Provider.

If We consider Your Concurrent Claim on an Urgent basis, We will notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than twenty-four (24) hours after We received Your Appeal. If We notify You of Our decision orally, We will send You written confirmation within three (3) days after receiving Your Claim.

If We deny Your Claim (if we do not agree to pay for extending the ongoing course of treatment or services), our Adverse Benefit Determination notice will tell you why We denied Your Claim and how You can appeal.

b. Non-Urgent Concurrent Care First Level Appeal

Within one hundred eighty (180) days after you receive our Adverse Benefit Determination notice, you must tell us by either calling us or writing to us that you want to appeal our Adverse Benefit Determination. We will count the one hundred eighty (180) calendar days starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The ongoing course of covered treatment that you want to continue or extend, (4) All of the reasons why you disagree with our Adverse Benefit Determination, and (5) All supporting documents. Your request and all supporting documents constitute Your Appeal. You must either mail or fax appeal to **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that five-day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send You a written decision as soon as possible if You care has not ended but not later than thirty (30) days after We receive Your Appeal.

If We deny Your Appeal, Our Adverse Benefit Determination decision will tell You why We denied Your Appeal and will include information about any further process, including External Review, that may be available to You.

c. Urgent Concurrent Care First Level Appeal

Tell us that You want to urgently appeal our Adverse Benefit Determination regarding Your urgent concurrent claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The ongoing course of covered treatment that You want to continue or extend, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal. You can appeal orally by calling Member Services or in writing by mailing or sending by fax to the **Appeals Program** at:

Permanente Advantage
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-525-1533 (office)
1-866-338-0266 (fax)

When You send Your Appeal, You may also request simultaneous External Review of Our Adverse Benefit Determination. If You want simultaneous External Review, Your Appeal must tell Us this.

You will be eligible for the simultaneous External Review only if Your Concurrent Care Claim qualifies as Urgent. If You do not request simultaneous External Review in Your Appeal, then You may be able to request External Review after We make Our decision regarding Your Appeal (see "External Review" in this **"APPEALS and COMPLAINTS"** section).

We will decide whether Your Appeal is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Appeal is Urgent. If We determine that Your Appeal is not Urgent, We will treat Your Appeal as Non-Urgent. Generally, an Appeal is Urgent only if using the procedure for Non-Urgent Appeals (a) Could seriously jeopardize Your life, health, or ability to regain maximum function: or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without continuing Your course of covered treatment,. We may, but not required to waive the requirements related to an Urgent appeal to permit you to pursue an Expedited External Review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written complaints, documents, record and other materials for the reviewer or reviewers to consider; and to receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review Your Appeal and notify You of Our decision orally or in writing as soon as Your clinical condition requires, but no later than seventy-two (72) hours after we receive Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information about any further process, including External Review, that may be available to You.

3. Post-Service Claims and Appeals

Post-service Claims are requests that We for pay for Services You already received, including Claims for Out-of-Plan Emergency Services. If You have any general questions about Post-Service Claims or Appeals, please call **Customer Service** at 1-855-364-3184 or 711 (TTY).

Here are the procedures for filing a Post-Service Claim and a Post-service Appeal:

a. Post-Service Claim

Within twelve (12) months from the date You received the Services, mail Us a letter explaining the Services for which You are requesting payment. Provide Us with the following: (1) The date You received the Services, (2) Where You received them, (3) Who provided them, and (4) Why You think We should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute Your Claim. Or, You may contact **Customer Service** at 1-855-364-3184 or 711 (TTY) to obtain a Claims form. You must mail Your Claim to **Claims Department** at:

National Claims Administration- Colorado
PO Box 373150
Denver, CO 80237-9998

We will not accept or pay for Claims received from You after twelve (12) months from the date of Services.

We will review Your Claim, and if We have all the information We need We will send You a written decision within thirty (30) days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision,

if We notify You within fifteen (15) days after We receive Your Claim and explain the circumstances and the reason for the extension and when we expect to make the decision. If We tell You We need more information, We will ask You for the information and We will give you forty-five (45) days from the date of Your receipt of Our notice to send Us the information. We will make a decision within fifteen (15) days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within forty-five (45) days after We send Our request, We will make a decision based on the information We have within fifteen (15) days following the end of the forty-five (45) day period

If We deny Your Claim (if We do not pay for all the Services You requested), Our Adverse Benefit Determination notice will tell You why We denied Your Claim and how You can appeal.

b. Post-Service First Level Appeal

Within one hundred eighty (180) days after You receive Our Adverse Benefit Determination, tell Us in writing that You want to appeal Our denial of Your Post-service Claim. We will count the one hundred eighty (180) calendar days starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The specific Services that You want Us to pay for, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) Include all supporting documents such as medical records. Your request and the supporting documents constitute Your Appeal. You must either mail or fax Your Appeal to:

Member Appeals Program
PO Box 378066
Denver, CO 80237
1-888-370-9858 (office)
1-866-466-4042 (fax)

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that 5-day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send You a written decision within 30 days after We receive Your Appeal.

If We deny Your Appeal, Our Adverse Benefit Determination will tell You why We denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

Appeals of Retroactive Coverage Termination (Rescission or Retroactive Cancellation)

We may terminate your coverage retroactively (see Rescission for Fraud or Intentional Misrepresentation under **TERMINATION/NON-RENEWAL/CONTINUATION** section). We will send you written notice at least thirty (30) days prior to the termination. If you have general questions about retroactive coverage terminations or appeals, please call the **Customer Service** at 1-855-364-3184.

Here is the procedure for filing an appeal of a retroactive coverage termination:

Within one hundred eighty (180) days after you receive our Adverse Benefit Determination that your coverage will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your coverage retroactively. Please include the following: (1) Your name and Medical Record Number, (2) All of the reasons why you disagree with our retroactive membership termination, and (3) All supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 378066
Denver, CO 80237

We will review your appeal and send you a written decision within thirty (30) days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including External Review, that may be available to you.

Voluntary Second Level Appeal

A Voluntary Second Level Appeal is another review by Us that occurs after the mandatory internal Appeal decision is communicated to You if You remain dissatisfied with Our decision. This in-person review permits You to present evidence to the Second Level Appeal Panel and to ask questions**. Choosing a Voluntary Second Level Appeal will not affect Your right, if you have one, to request an independent External Review.**

Here is the procedure for a Voluntary Second Level of Appeal for medical benefits and Outpatient Prescription Drugs:

Within sixty (60) days from the date of Your receipt of Our notice regarding Your First Level of Appeal decision, we must receive your Voluntary Second Level Appeal requesting the review of the adverse decision. We will count the sixty (60) days starting five (5) business days from the date of the First Level of Appeal decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) The specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination (mandatory internal Appeal decision), and (5) All supporting documents. Your request and the supporting documents constitute Your request for a Voluntary Second Level of Appeal. You must either mail or fax Your Appeal to:

Kaiser Permanente Insurance Company (KPIC)
Grievance and Appeals Coordinator
1800 Harrison Street, 20th Floor
Oakland, CA 94612
1-877-727-9664 (fax)

Within sixty (60) calendar days following receipt of Your request, KPIC will hold a Voluntary Second Level Appeal meeting. KPIC shall notify You of the date on which the Voluntary Second Level Appeal Panel will meet at least twenty (20) days prior to the date of this in-person meeting. You have the right to request a postponement by calling **Membe**r **Appeals Program** at 1-888-370-9858 and your request cannot be unreasonably denied. You have the right to appear in person or by telephone conference at the review meeting. We will make our decision within seven (7) days of the completion of this meeting.

You may present Your Appeal in person before the Voluntary Second Level Appeal Panel, or request a file review. If You would like to present Your Appeal in person, but an in-person meeting is not practical, You may present Your Appeal by telephone by calling e **Member Appeals Program** at 1-888-370-9858. Please indicate in Your Appeal request how you want to present Your Appeal. Unless you request to be present for the special meeting in person or by telephone conference, we will conduct your appeal as a file review

You may request in writing that KPIC transmit all material that will be presented to the Voluntary Second Level Appeal Panel at least five (5) days prior to the date of the Voluntary Second Level Appeal meeting.

You may submit additional information with Your Appeal request, or afterwards but no later than five (5) days prior to the date of Your Voluntary Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to Us as soon as practicable. You may present Your case to the Voluntary Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of Your choice including an attorney (at Your own expense), other advocate or health care professional. If You decide to have an attorney present at the Voluntary Second Level Appeal meeting, then You must let Us know that at least seven (7) days prior to that meeting. You must appoint this attorney as Your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If You would like further information about the Voluntary Second Level Appeal process, to assist You in making an informed decision about pursuing a Voluntary Second Level Appeal, please call **Member Appeals Program** at 1-888-370-9858. Your decision to pursue a Voluntary Second Level Appeal will have no effect on Your rights to any other benefits under this health insurance plan, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse First Level Appeal or Voluntary Second Level Appeal decision letter, You may have a right to request an External Review. There is no minimum dollar amount for a claim to be eligible for an External Review. You will not be responsible for the cost of the External Review.

You have the right to request an independent External Review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) A denial of a preauthorization for a Service; (2) A denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) A denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for External Review. However, independent External Review is available when we deny your appeal because you request medical care that is excluded under your plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

To request External Review, You must submit a completed Independent External Review of Carrier's Final Adverse Determination form (you may call **Member Appeals Program** at 1-888-370-9858 to request another copy of this form) which will be included with the mandatory internal appeal decision letter and explanation of Your Appeal rights, to **Member Appeals Program** within four (4) months of the date of receipt of Our mandatory First Level Appeal decision or of Our Voluntary Second Level Appeal decision. We shall consider the date of receipt for Our notice to be three (3) days after the date on which Our notice was postmarked, unless You can prove that You received our notice after the three (3)-day period ends.

You must include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Appeals Program** at 1-888-370-9858 to request a copy of this form).

If We do not receive Your External Review request form and/or authorization form to release your health information, then We will not be able to act on Your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for Your request of External Review.

Expedited External Review

You may request an Expedited External Review if (1) You have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize Your life, health, or ability to regain maximum function; or, (2) If You have a physical or mental existing disability that creates an imminent and substantial limitation to Your existing ability to live independently, or (3) In the opinion of a Physician with knowledge of Your medical condition, the timeframe for completion of a standard review would subject You to severe pain that cannot be adequately managed without the medical services that You are seeking.

You may request Expedited External Review simultaneously with your expedited internal appeal as permitted under this Plan. A request for an Expedited External Review must be accompanied by a written statement from Your Physician that Your condition meets the expedited criteria. You must include the Physician's certification that You meet External Review criteria when You submit Your request for External Review along with the other required information (described, above). No Expedited External Review is available when You have already received the medical care that is the subject of Your request for External Review. If You do not qualify for Expedited External Review, We will treat Your request as a request for Standard External Review.

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request External Review or expedited External Review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for External Review or expedited External Review must include a written statement from your physician that either (a) Standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b)There is no available standard health care service or treatment covered under this plan that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited External Review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for External Review.

After we receive your request for External Review, we shall notify you of the information regarding the independent External Review entity that the Division of Insurance has selected to conduct the External Review.

If We deny Your request for Standard or Expedited External Review, including any assertion that We have not complied with the applicable requirements related to Our Internal Claims and Appeals Procedure, then We may notify You in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that We send this denial notice to You, We will send a copy of it to the Division of Insurance.

You will not be able to present Your Appeal in person to the Independent External Review Organization. You may, however, send any additional information that is significantly different from information provided or considered during the Internal Claims and Appeal Procedure and, if applicable Voluntary Second Level of Appeal process. If You send new information, We may consider it and reverse our decision regarding Your Appeal.

You may submit Your additional information to the Independent External Review Organization for consideration during its review within five (5) working days of Your receipt of Our notice describing the Independent Review Organization that has been selected to conduct the External Review of Your Claim. Although it is not required to do so, the Independent Review Organization may accept and consider additional information submitted after this five (5)-working day period ends.

The Independent External Review entity shall review information regarding Your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within forty-five (45) days of the Independent External Review entity's receipt of Your request for Standard External Review,

it shall provide written notice of its decision to You. If the Independent External Review entity is deciding Your Expedited External Review request, then the Independent External Review entity shall make its decision as expeditiously as possible and no more than seventy-two (72) hours after its receipt of Your request for External Review and within forty-eight (48) hours of notifying You orally of its decision provide written confirmation of its decision. This notice shall explain that the External Review decision is the final appeal available under state insurance law. An External Review decision is binding on KPIC and You except to the extent KPIC and You have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for External Review involving the same adverse determination for which you have already received an External Review decision.

If the Independent External Review Organization overturns Our denial of payment for care You have already received, We will issue payment within five (5) working days. If the Independent Review organization overturns Our decision not to authorize Pre-service or Concurrent Care Claims, KPIC will authorize care within one (1) working day. Such Covered Services shall be provided subject to the terms and conditions applicable to benefits under this health insurance plan.

Except when External Review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, You must exhaust Our Internal Claims and Appeals Procedure (but not the Voluntary Second Level of Appeal) for Your Claim before You may request External Review, unless We have failed to comply with federal and/or state law requirements regarding Our Claims and Appeals Procedures.

Additional Review

You may have certain additional rights if You remain dissatisfied after You have exhausted Our Internal Claims and Appeals Procedures, and if applicable, External Review. If You are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), You may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if Your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), You may have a right to request review in state court.

INFORMATION ON POLICY AND RATE CHANGES

Entire Contract and Changes
The Policyholder will act on behalf of all the Insured Employees in all matters pertaining to the Group Policy, and the following will be binding upon all Covered Persons: (1) every act done by the Policyholder; (2) every agreement between KPIC and the Policyholder; and (3) every notice given by either party to the other.

The entire contract between the Policyholder and KPIC consists of the Group Policy, certificates, amendments or riders incorporated by reference, the attached application of the Policyholder; and the applications, on file, if any, of the Insured Employees. All statements made by the Policyholder or Insured Employees will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or Insured Employees will be used in defense to a claim under the Group Policy, unless it is contained in a written application.

No change in the Group Policy will be valid unless:
1. It is noted on, or attached to, the Group Policy;
2. Signed by an executive officer of KPIC; and
3. Delivered to the Policyholder.

KPIC may change, cancel, or discontinue coverage, to the extent permitted by law, provided under the Group Policy without the consent of the Policyholder or Insured Employees. Payment of premium, after a change has been made and incorporated into the Group Policy, will be deemed acceptance of the changes made by KPIC. The Policyholder must mail or deliver notice of cancellation or discontinuance to all Insured Employees at least thirty-one (31) days prior to the date of cancellation or discontinuance of the Group Policy. Notice to the Insured Employee will be considered notice to any Insured Dependent of the Insured Employee.

No agent has the authority to:
1. Change the Group Policy;
2. Waive any provisions of the Group Policy;
3. Extend the time for payment of premiums; or
4. Waive any of KPIC's rights or requirements.

Premium Rates
KPIC may change any of the premium rates as of any Group Policy Anniversary, or at any other time by written agreement between the Policyholder and KPIC on any premium due date when:
1. The terms of the Group Policy are changed;
2. A division, a subsidiary or an affiliated company is added to the Group Policy; or
3. For reasons other than the above, such as, but not limited to, a change in factors bearing on the risk assumed. The rate may not be changed within the first six months following the Group Policy Effective Date.

KPIC will give the Policyholder thirty-one (31) days advance written notice of any change in premium.

KPIC will give the Policyholder a thirty-one (31) day grace period for the payment of any premium.

DEFINITIONS

The following terms have special meaning throughout this Certificate. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Certificate are defined in those sections.

"A" Recommendation means a recommendation adopted by the Task Force, which strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

Accumulation Period – The time period set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

ACIP means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the Federal Department of Health and Human Services, or any successor entity.

Administrator means Kaiser Foundation Health Plan of Colorado. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor its Administrator is the administrator of the Policyholder's employee benefit plan as that term is defined under Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA) as then constituted or later amended.

Applied Behavior Analysis means the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: (a) A federally funded or approved trial; (b) a clinical trial conducted under an FDA investigational new drug application; or (c) A drug that is exempt from the requirement of an FDA investigational new drug application.

Autism Services Provider means any person, who provides direct services to Covered Persons with Autism Spectrum Disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets one of the following:

1. Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one (1) year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
2. Has a doctoral degree in one of the behavioral or health sciences and has completed one (1) year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
3. Has a master's degree or higher in behavioral sciences and is nationally certified as a "Board Certified Behavior Analyst" or certified by a similar nationally recognized organization; or
4. Has a master's degree or higher in one (1) of the behavior or health sciences, is credentialed as a "Related Services Provider," and has completed one (1) year of direct supervised experience in behavioral therapies. Related Services Provider means physical therapist, an occupational therapist or speech therapist that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
5. Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a Board-Certified Associate Behavior Analyst or certified by a similarly recognized organization; or
6. Is nationally registered as a "registered behavior technician" by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with an Autism Spectrum Disorder under the supervision of an Autism Services Provider described in sub-subparagraph (1), (2), (3), (4), or (5) above.

DEFINITIONS

Autism Spectrum Disorders (ASD) means a disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis; and includes the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis: Autistic Disorder, Asperger's Disorder, and atypical Autism, as a diagnosis within pervasive developmental disorder, not otherwise specified.

Autism Treatment Plan means a plan developed for a Covered Person by an Autism Services Provider and prescribed by a Physician and licensed psychologist pursuant to comprehensive evaluation or reevaluation for a Covered Person consisting of the Covered Person's diagnosis, proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which by which the plan will be updated. The Treatment Plan shall be developed in accordance with patient-centered medical home, as defined under applicable Colorado law

"B" Recommendation means a recommendation adopted by the Task Force, which recommends that clinicians provide a preventive health care service because the Task Force found there is high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.

Behavioral Health, Mental Health and Substance Use Disorder:

1) Means a condition or disorder, regardless of etiology, that maybe the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the Mental Disorders section of the most recent version of:
   (a) The International Statistical Classification of Diseases and Health Related Problems;
   (b) The Diagnostic and Statistical Manual of Mental Disorders; or
   (c) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and
2) Includes Autism Spectrum Disorder

Benefit Maximum means a maximum amount of benefits that will be paid by KPIC for a specified type of Covered Charges incurred during a given period of time. The charges to which a Benefit Maximum applies are not considered Covered Charges after the Benefit Maximum has been reached. Covered Charges in excess of the Benefit Maximum will not be applied toward satisfaction of the Accumulation Period Deductible and Out-of-Pocket Maximum. Benefit Maximum does not apply to Essential Health Benefits, as defined under this health insurance plan, received at either the Participating Provider level or the Non-Participating level.

Birth Center means an outpatient facility which:

1. Complies with licensing and other legal requirements in the jurisdiction where it is located;
2. Is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal to low risk patients;
3. Has organized facilities for Birth Services on its premises;
4. Has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a Licensed Midwife or Certified Nurse Midwife; and
5. Has 24-hour-a-day Registered Nurse services.

Birth Services means ante partum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: (1) uncomplicated pregnancy and labor; and (2) spontaneous vaginal delivery.

Benefits payable for the treatment of complications of pregnancy will be covered on the same basis as any other Sickness.

Calendar Year means a period of time: (1) beginning at 12:01 a.m. on January 1st of any year; and (2) terminating at midnight on December 31st of that same year.

DEFINITIONS

Certified Nurse-Midwife or Licensed Midwife means any person duly certified or licensed as such in the state in which treatment is received and is acting within the scope of his or her license at the time the treatment is performed.

Certified Nurse Practitioner means a Registered Nurse duly licensed in the state in which the treatment is received who has completed a formal educational nurse practitioner program. He or she must be certified as such by the: (1) American Nurses' Association; (2) National Board of Pediatric Nurse Practitioners and Associates; or (3) Nurses' Association of the American College of Obstetricians and Gynecologists.

Certified Psychiatric-Mental Health Clinical Nurse Specialist means any Registered Nurse licensed in the state in which the treatment is received who: (1) has completed a formal educational program as a psychiatric-mental health clinical nurse specialist; and (2) is certified by the American Nurses' Association.

Child Health Supervision Services means those preventive services and immunizations required to be provided in a Colorado basic and standard health benefit plan in accordance with Colorado Code Section 10-16-105 (7.2), as then constituted and later amended to covered Dependent children up through age twelve (12). Services must be provided by a Physician or pursuant to a physician's supervision or by a primary health care provider who is a Physician's assistant or Registered Nurse who has additional training in child health assessment and who is working in collaboration with a Physician.

Clean Claim means a claim for payment of health care expenses that is submitted to KPIC or its administrator on its standard claim form with all required fields completed with correct and complete information in accordance with KPIC's published filing requirements. A Clean Claim does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

Clinical Social Worker means a person who is licensed as a clinical social worker, and who has at least five years of experience in psychotherapy (as defined by the state of Colorado) under appropriate supervision, beyond a master's degree.

Clinical Trial means an experiment, in which a drug or device is administered to dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs, as well as the use of drug in combination with alternative therapy or dietary supplement.

Coinsurance means a percentage of charges that You must pay as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section when You receive a Covered Service as described under the **BENEFITS/COVERAGE (What is Covered)** section and the Policy Schedule. Coinsurance amount is applied against the Covered Charge.

Complications of Pregnancy means (1) conditions when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity;
(2) Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include conditions such as false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Complications of Pregnancy are covered under this Certificate as any other Sickness or Injury.

Comprehensive Rehabilitation Facility means a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled

individuals. The facility must be accredited for the provision of these services by the Commission on Accreditation of Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

Confinement means physically occupying a room and being charged for room and board in a Hospital or other covered facility on a twenty-four hour a day basis as a registered inpatient upon the order of a Physician.

Copayment means the predetermined amount, as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section, which is to be paid by the Insured for a Covered Service, usually at the time the health care is rendered. All Copayments applicable to the Covered Services are shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Cosmetic Surgery means surgery that: (a) is performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance; and (b) will not result in significant improvement in physical function. Cosmetic Surgery is not covered under this Policy.

Cost Share means a Covered Person's share of Covered Charges. Cost Share includes and is limited only to the following: 1) Coinsurance; 2) Copayment; 3) per benefit deductibles; and 4) Deductible.

Covered Charge or Covered Charges means the Maximum Allowable Charge(s) for a Covered Service.

Covered Person means a person covered under the terms of the Group Policy. A Covered Person who is enrolled as an Insured Employee or Insured Dependent under the Plan. Also, sometimes referred to as member. No person may be covered as both an Insured Employee and a Dependent at the same time under a single Group Policy.

Covered Services means those services which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section entitled **BENEFITS/COVERAGE (What is Covered).**

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during that Accumulation Period.

Some Covered Services are subject to additional or separate deductible amounts as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. These additional or separate deductibles are neither subject to, nor do they contribute towards the satisfaction of the Self-Only Deductible or Individual Deductible or the Family Deductible Maximum.

Dependent means:

1. Your lawful spouse, partner in a civil union or Domestic Partner (if Domestic Partner is covered under this plan); or
2. Your or Your spouse's, Your partner in a civil union or Your Domestic Partner natural or adopted or foster child, if that child is under age the age of 26.
3. Other unmarried dependent person who meets all of the following requirements:
   a) Is under the dependent limiting age specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section; and
   b) You or Your Spouse, Your partner in a civil union or Your Domestic Partner is the court-appointed permanent legal guardian or was before the person reached age 18.
4. Your or Your Spouse's Your partner in a civil union, Your Domestic Partner unmarried child of any age; who is medically certified as disabled and dependent upon You, Your Spouse, Your partner in a civil union or Your Domestic Partner, are eligible to enroll or continue coverage as Your Dependents if the following requirements are met:
   a) They are dependent on You or Your Spouse, Your partner in a civil union or Your Domestic Partner; and
   b) You give us proof of the Dependent's disability and dependency annually if We request it.

Detoxification means the process of removing toxic substances from the body.

Domestic Partner means an unmarried adult who resides with the Insured Employee for at least six (6) months in a committed relationship. A Domestic Partner may be regarded as a Dependent, upon meeting Our prescribed requirements, which include the following:

1. Both persons must have a common residence for a period of at least six months prior to eligibility for this coverage;
2. Both persons must agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
3. Neither person is married nor a member of another domestic partnership or have been a party to a domestic partnership that was terminated within twelve (12) months before becoming eligible for this coverage;
4. The two persons are not related by blood in a way that would prevent them from being married to each other in conformity with state law;
5. Both persons must be at least 18 years of age and be the same sex;
6. Both persons must be capable of consenting to the domestic partnership;
7. Neither person is legally married to or legally separated from another person; and
8. Both persons must have duly executed a declaration of domestic partnership on a form agreed to by Us.

Durable Medical Equipment means equipment which:

1. Is designed for repeated use;
2. Can mainly and customarily be used for medical purposes;
3. Is not generally of use to a person in the absence of a Sickness or Injury;
4. Is approved for coverage under Medicare, including insulin pumps and insulin pump supplies;
5. Is not primarily or customarily for the convenience of the Covered Person;
6. Provides direct aid or relief of the Covered Person's medical condition;
7. Is Appropriate for use in the home;
8. Serves a specific therapeutic purpose in the treatment of an illness or injury; and
9. Is an infant apnea monitor.

Durable Medical Equipment does not include:

1. Oxygen tents;
2. Equipment generally used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, bathtub lifts, adjust-a-beds, telephone arms, air conditioners, and humidifiers);
3. Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Covered Person's condition and in order for the Covered Person to operate the equipment;
4. Disposable supplies, exercise and hygiene equipment, experimental or research equipment, and devices not medical in nature such as sauna baths, elevators, or modifications to the home or automobile. This exclusion does not apply to disposable diabetic supplies;
5. Devices for testing blood or other body substances, except diabetic testing equipment and supplies;
6. Electronic monitors of bodily functions, except infant apnea monitors;
7. Replacement of lost equipment;
8. Repair, adjustments, or replacements necessitated by misuse;
9. More than one piece of Durable Medical Equipment serving essentially the same function; except for replacements other than those necessitated by misuse or loss; and
10. Spare or alternate use equipment.

Early Childhood Intervention Services means services as defined by the Colorado Department of Human Services in accordance with Part C of the Individuals with Disabilities Education Act of 2004, as then constituted and later amended, that are authorized through an Insured Dependent's Individualized Family Service Plan, but excluding non-emergency medical transportation; respite care; service coordination, as defined under applicable federal regulation; and assistive technology.

Eligible Employee means a person who, at the time of original enrollment: (a) is working for a Policyholder as a full-time employee as described below or is entitled to coverage under an employment contract; (b)

by virtue of such employment or contract enrolls under the Group Policy and (c) reached an eligibility date. Eligible Employee includes sole proprietors, partners of a partnership, or independent contractor if they are included as employees under a health benefit plan of the Policyholder, engaged on a full-time basis in the employer's business or are entitled to coverage under an employment contract.

The term Eligible Employee does not include employees who work on a temporary seasonal or substitute basis.

Eligible Insured Dependent means an infant or toddler, from birth up to the child's third birthday, who has significant delays in development or has a diagnosed physical or mental condition that has high probability or resulting in significant delays in development or who is eligible for Early Childhood Intervention Services pursuant to applicable Colorado law. Please refer to the definition of Insured Dependent.

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

1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient

Emergency Medical Condition: A medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Essential Health Benefits means the general categories of benefits including the items and services covered within these categories of benefits that comprise an essential health benefit package as defined under the Patient Protection and Affordable Care Act of 2010 (PPACA) as then constituted or later amended.

Expense(s) Incurred means expenses a Covered Person incurs for Covered Services. An expense is deemed incurred as of the date of the service, treatment, or purchase.

Formulary means a list of prescription drugs we cover.

Free-Standing Surgical Facility means a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:

1. Has permanent operating rooms;
2. Has at least one recovery room;
3. Has all necessary equipment for use before, during and after surgery;
4. Is supervised by an organized medical staff, including Registered Nurses available for care in an operating or recovery room;
5. Has a contract with at least one nearby Hospital for immediate acceptance of patients requiring Hospital care following care in the Free-Standing Surgical Facility;
6. Is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. Requires that admission and discharge take place within the same working day.

Group Policy means the health insurance contract issued by KPIC to the Policyholder that establishes the rights and obligations of KPIC and the Policyholder.

DEFINITIONS

Habilitative Services means services and devices that help a person retain, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of outpatient settings. **Health Plan** means Kaiser Foundation Health Plan of Colorado.

Health Plan Evidence of Coverage describes the health care coverage provided under the group agreement between the Kaiser Foundation Health Plan of Colorado (Health Plan) and your group.

HMO coverage means services provided, authorized or arranged by Health Plan under a separate agreement.

HMO Physician/Provider is a physician or provider contracted with the Health Plan to provide services under the Health Plan's Evidence of Coverage.

Home Health Agency means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies and is engaged in arranging and providing nursing services, Home Health Services, and other therapeutic and related services.

Home Health Visit is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to four hours by a home health aide shall be considered as one visit

Homemaker Services means services provided to a Covered Person for Hospice Care which include:
1. General household activities including the preparation of meals and routine household care; and
2. Teaching, demonstrating and providing the Covered Person or their family with household management techniques that promote self-care, independent living and good nutrition.

Hospice Care means home-based palliative and supportive care by a licensed hospice for terminally ill patients. The care must be provided: (1) directly; or (2) on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For Hospice Care, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 months.

Hospital means an institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:
1. Is legally operated as a Hospital in the jurisdiction where it is located;
2. Is engaged mainly in providing inpatient medical care and treatment for Injury and Sickness in return for compensation;
3. Has organized facilities for diagnosis and major surgery on its premises;
4. Is supervised by a staff of at least two Physicians;
5. Has 24-hour-a-day nursing service by Registered Nurses; and
6. Is not: a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; or a Skilled Nursing Facility or similar institution.

The term **Hospital** will also include a psychiatric health facility which is currently licensed or certified by the Colorado Department of Public Health and Environment pursuant to the Department's authority under applicable Colorado law.

Hospital Confinement means being registered as an inpatient in a Hospital upon the order of a Physician.

Individualized Education Plan means a written plan for an Insured Dependent with a disability that is developed, reviewed, and revised in accordance with Colorado's applicable statutory and regulatory standards.

Individualized Family Service Plan is a written plan developed pursuant of to applicable federal statutory and regulatory standards, which authorizes the provision of Early Childhood Intervention Services to an Eligible Insured Dependent and to his or her family.

Individualized Plan means a written plan designed by an interdisciplinary team for the purpose of identifying the following: (a) needs of the Covered Person or family receiving the services; (b) the specific services and supports appropriate to meet such needs; (c) the projected date of initiation of services and supports; and (d) the anticipated results to be achieved by receiving the services and supports.

Injury means accidental bodily Injury of a Covered Person.

Insured Dependent means a Covered Person who is a Dependent of an Insured Employee.

Insured Employee means a Covered Person who is an Eligible Employee of the Policyholder or is one entitled to coverage under a welfare trust agreement.

Intensive Care Unit means a section, ward or wing within the Hospital which:
1. Is separated from other Hospital facilities;
2. Is operated exclusively for the purpose of providing professional care and treatment for critically-ill patients;
3. Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. Provides Room and Board; and
5. Provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Interdisciplinary Team means a group of qualified individuals, which includes, but is not limited to, a Physician, Registered Nurse, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice patients and their families.

Intractable Pain means a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

Licensed Vocational Nurse (LVN) means an individual who has (1) specialized nursing training; (2) vocational nursing experience; and (3) is duly licensed to perform nursing service by the state in which he or she performs such service.

Maximum Allowable Charge means:
1. For Covered Services from Participating Providers, the Negotiated Rate as defined under Paragraph 4 (b).
2. For Covered Services from Non-Participating Providers rendering the following services in the state of Colorado:
   (a) Emergency or Non-Emergency Services rendered in Participating facilities by physicians and other professionals that are Non-Participating Providers:
   (b) Emergency Services rendered in a non-Denver Health Hospital Authority operated Non-Participating facility.
   (c) Emergency Services rendered in a Denver Health Hospital Authority operated Non-Participating Provider facility.

   the reimbursement rate according to state law.

   Other than applicable cost sharing (Deductible, Coinsurance or Copayments) Non-Participating Providers rendering services in the state of Colorado may not balance bill a Covered Person for the difference between the Maximum Allowable Charge and the Actual Billed Charges. However, a Non-

Participating Provider may balance bill a Covered Person when the Covered Person chooses to use the Non-Participating Provider.

3. For Emergency Services rendered by Non-Participating Providers outside the state of Colorado, the following rules apply:

   If the amount payable by KPIC is less than the Actual Billed Charges by Non-Participating Providers for Emergency Service, KPIC will pay no less than the greatest of the following:
   (a) The Negotiated Rate for the service. If there is more than one Negotiated Rate with a Participating Provider for a particular service, then such amount is the median of these Negotiated Rate, treating the Negotiated Rate with each provider as a separate Negotiated Rate, and using an average of the middle two Negotiated Rates if there is an even number of Negotiated Rates.
   (b) The amount it would pay for the service if it used the same method (for example, Usual and Customary charges) that it generally uses to determine payments for services rendered by Non-Participating Providers and if there were no Cost Share (for example, if it generally pays 80% of UCR and the Cost Share is 20%, this amount would be 100% of UCR).
   (c) The amount that Medicare (Part A or B) would pay for the service.

4. For all other Covered Services from a Non-Participating Provider, the lesser of:
   (a) The Usual, Customary and Reasonable Charge (UCR):
   The Usual, Customary & Reasonable (UCR) Charge is the lesser of: or
      (i) The charge generally made by a Physician or other supplier of services, medicines, or supplies;
      (ii) The general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

   The term "area" as it would apply to any particular service, medicine or supply means a city or such greater area as is necessary to obtain a representative cross section of level of charges.

   If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to the Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges. Such difference will not apply towards satisfaction of the Out-of-Pocket Maximum nor any Deductible under the Group Policy.

   (b) The Negotiated Rate:
   KPIC or its authorized Administrator may have a contractual arrangement with the provider or supplier of Covered Services under which discounts have been negotiated for certain services or supplies. Any such discount is referred to as the Negotiated Rate.

   If there is a Negotiated Rate, the provider will accept the Negotiated Rate as payment in full for Covered Services, subject to the payment of Deductibles and coinsurance by the Covered Person.

   (c) The Actual Billed Charges for the Covered Services:
   The charges billed by the provider for Covered Services.

IMPORTANT: Notwithstanding the foregoing, the Maximum Allowable Charge for a Hospital or other licensed medical facility confinement may not exceed:

Hospital Routine Care Daily Limit:	the Hospital's average semi-private room rate
Intensive Care Daily Limit:	the Hospital's average Intensive Care Unit room rate
Other licensed medical facility Daily Limit:	the facility's average semi-private room rate

Maximum Benefit While Insured means the dollar limitation of Covered Charges as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section that will be paid for a Covered Person, while covered under the Group Policy. Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured at the Participating Provider level.

Medical Foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formula are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via a tube or oral route under the direction of Participating Physician. This definition shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

Medically Necessary means services that, in the judgment of KPIC, are:

1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility;
6. Not primarily custodial care;
7. Not experimental or investigational; and
8. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

   The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

Medically Necessary Leave of Absence or Medical Leave of Absence means a leave of absence from a post-secondary educational institution or a change in enrollment of the dependent at the institution that: (a) begins while the Dependent is suffering from a serious illness; (b) is medically necessary, and (c) causes the Dependent to lose student status for the purpose of Dependent coverage

Medical Review Program means the organization or program that (1) evaluates proposed treatments and/or services to determinate Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours a day, seven days a week.

Medical Social Services means those services provided by an individual who possesses a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience. Such services are provided at the recommendation of a Physician for the purpose of assisting a Covered Person or the family in dealing with a specific medical condition.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Mental Health Please refer to the definition of **Behavioral Health, Mental Health and Substance Use Disorder** above.

DEFINITIONS

Month means a period of time: (1) beginning with the date stated in the Group Policy; and (2) terminating on the same date of the succeeding calendar month. If the succeeding calendar month has no such date, the last day of the month will be used.

Necessary Services and Supplies means Medically Necessary Covered Services and supplies actually administered during any covered confinement or administered during other covered treatment. Only drugs and materials that require supervision or administration by medical personnel during a covered confinement or other covered treatment are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to, surgically implanted prosthetic devices, F, blood, blood products, and biological sera. The term does not include charges for: (1) Room and Board; (2) an Intensive Care Unit; or (3) the services of a private duty nurse, Physician, or other practitioner.

Negotiated Rate means the fees KPIC has negotiated with a Provider to accept as payment in full for Covered Services rendered to Covered Persons.

Non-Participating Pharmacy means a pharmacy that does not have a Participating Pharmacy agreement with KPIC or its administrator in effect at the time services are rendered. Please consult with Your group administrator for a list of Participating Pharmacies.

Non-Participating Provider means a Hospital, Physician or other duly licensed health care provider or facility that does not have a participation agreement with KPIC or KPIC's Provider network in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your bill when You visit a Non-Participating Provider. Participating Providers are listed in the Participating Provider directory.

Open Enrollment Period means a fixed period of time, occurring at least once annually, during which Eligible Employees of the Policyholder may elect to enroll under this health insurance plan without incurring the status of being a Late Enrollee.

Orthotics means rigid or semi rigid external devices which: a) support or correct a defective form or function of an inoperative or malfunctioning body part; or b) restrict motion in a diseased or injured part of the body. Orthotics do not include casts.

Out-of-Pocket means the Cost Share incurred by a Covered Person.

Out-of-Pocket Maximum means the maximum amount of Cost Share a Covered Person will be responsible for in an Accumulation Period.

Palliative Services means those services and/or interventions which produce the greatest degree of relief from the symptoms of a terminal Sickness.

Partial Hospitalization means continuous treatment for at least three (3) hours, but not more than twelve (12) hours, in any 24-hour period.

Participating Pharmacy means a pharmacy which has a Participating Pharmacy agreement in effect with KPIC at the time services are rendered. Please consult with Your group administrator for a list of Participating Pharmacies.

Participating Provider means a health care provider duly licensed in the state in which such provider is practicing, including a Primary Care Physician, Specialty Care Physician, Hospital, Participating Pharmacy, laboratory, other similar entity under a written contract with a Preferred Provider Organization (PPO), KPIC or its Administrator. Please consult with Your group administrator for a list of Participating Providers.

Patient Protection and Affordable Care Act (PPACA) – means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended.

DEFINITIONS

Percentage Payable means that percentage of Covered Charges to be paid by KPIC The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services.

Physician means a practitioner who is duly licensed as a Physician in the state in which the treatment is received. He or she must be practicing within the scope of that license. The term does not include a practitioner who is defined elsewhere in this **DEFINITIONS** section.

Placement for Adoption means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates.

Plan/This health insurance plan means the part of the Group Policy that provides benefits for health care expenses. If "Plan" has a different meaning for another section of this Certificate, the term will be defined within that section and that meaning will supersede this definition only or that section.

Policyholder means the employer(s) or trust(s) or other entity noted in the Group Policy as the Policyholder who conforms to the administrative and other provisions established under the Group Policy.

Policy Year means a period of time: (1) beginning with this health insurance plan Effective Date of any year; and (2) terminating, unless otherwise noted on the Group Policy, on the same date shown on the **SCHEDULE OF BENEFITS (Who Pays What)** section. If this health insurance plan Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

Pre-certification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment other than outpatient prescription drugs, made by the Medical Review Program. Consistent with applicable Colorado law, the sole responsibility for obtaining any necessary Pre-certification rest with the Participating Provider, who recommends or orders Covered Services, and not with the Covered Person.

Pre-certification will not result in payment of benefits that would not otherwise be covered under the Group Policy.

Preferred Brand Name Prescription Drug means a prescription drug that has been patented and is only produced by one manufacturer and is listed in Our Preferred Drug List of preferred prescribed medication.

Preferred Drug List is a listing of preferred prescribed medications that are covered under Your group coverage. Such listing is subject to change on a quarterly basis. Any product, which is not indicated in the listing or in updates thereof, will be considered a non-preferred medication. You may request a copy of the **Preferred Drug List,** Our Formulary, by calling toll-free at (800) 788-2949 (Pharmacy Help Desk), Monday through Friday.

Preferred Generic Prescription Drug means a prescription drug which does not bear the trademark of a specific manufacturer. Such drug is also listed in Our Drug Formulary of preferred prescribed medication.

Preferred Provider Organization (PPO) means a KPIC plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred or Participating Providers. Generally, a higher level of benefits applies to Covered Services received from preferred or Participating Providers and facilities. The **SCHEDULE OF BENEFITS (Who Pays What)** section shows the plan type under which the Covered Person is insured.

Pregnancy means the physical condition of being pregnant, but does not include Complications of Pregnancy.

Preventive Care means measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

1. protects against disease such as in the use of immunizations,
2. promotes health, such as counseling on tobacco use, and

3. detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

   Unless otherwise specified, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to Preventive Care.

Primary Care Physician/Provider means a Physician or other licensed provider specializing in internal medicine, family practice, general practice, internal medicine, and pediatrics.

Prosthetic Devices (External) means a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Examples of external prosthetics includes artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eyeware after cataract surgery or eyeware to correct aphakia. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.

Prosthetic Devices (Internally implanted) means a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover internally implanted prosthetic devices that replace the function of all or part of an internal body organ, including internally implanted breast prostheses following a covered mastectomy. The devices must be approved for coverage under Medicare and for general use by the Food and Drug Administration (FDA). Examples of internally implanted prosthetics include pacemakers, surgically implanted artificial hips and knees and intraocular lenses.

Psychiatric Care means direct or consultative services provided by a psychiatrist, who is duly licensed by the State Board of Medical Examiner in accordance with applicable Colorado law.

Psychological Care means direct or consultative services provided by a psychologist, who is licensed by the State Board of Psychologist Examiners pursuant to applicable e Colorado law or a social worker, who is licensed by the State Board of Social Work Examiners pursuant to applicable Colorado law.

Reconstructive Surgery means a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance to the extent possible.

Registered Nurse (RN) means a duly licensed nurse acting within the scope of his or her license at the time the treatment or service is performed in the state in which services are provided.

Rehabilitation means services and devices provided to restore previously existing physical function which has been lost as a result of illness or injury when a physician determines that therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

Residential Treatment means Medically Necessary services provided in a licensed residential treatment facility that provides 24-hour individualized Substance Use Disorder or mental health treatment. Services must be above the level of custodial care and include:
1. room and board;
2. individual and group Substance Use Disorder therapy and counseling;
3. individual and group mental health therapy and counseling;
4. physician services;
5. medication monitoring;
6. social services; and
7. drugs prescribed by a physician and administered during confinement in the residential facility.

Room and Board means all charges commonly made by a Hospital or other inpatient medical facility on its own behalf for room and meals essential to the care of registered bed patients.

Routine Patient Care Costs means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an Approved Clinical Trial program, including the following:

1. Health care services typically provided absent a clinical trial.
2. Health care services required solely for the provision of the investigational drug, item, device, or service.
3. Health care services required for the clinically appropriate monitoring of the investigational item or service.
4. Health care services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service.
5. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine Patient Care Costs do not include the costs associated with the provision of any of the following:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Covered Person may require as a result of the treatment being provided for purposes of the clinical trial.
3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
4. Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy.
5. Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Sickness means an illness or a disease of a Covered Person. Sickness will include congenital defects or birth abnormalities.

Skilled Nursing Facility means an institution (or a distinct part of an institution) which:

1. provides 24-hour-a-day licensed nursing care;
2. has in effect a transfer agreement with one or more Hospitals;
3. is primarily engaged in providing skilled nursing care as part of an ongoing therapeutic regimen; and
4. is licensed under applicable state law.

Specialty Care Physician/Provider means a Physician or other licensed provider whose practice is limited to a certain branch of medicine, which includes non-standard medical-surgical services because of the specialized knowledge required for service delivery and management. Such services may include consultations with Physicians other than Primary Care Physicians in departments other than those listed under the definition of Primary Care Physician.

Specialty Care Visits means consultations with Specialty Care Physicians.

Specialty Drugs means prescribed medications such as self-injectable medications, as listed in Our Drug Preferred List. The level of coverage of Specialty Drugs is set forth in Your **SCHEDULE OF BENEFITS (Who Pays What)** section.

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

Substance Use Disorder– Please refer to the definition of **Behavioral Health, Mental Health and Substance Use Disorder** above.

DEFINITIONS

Task Force means the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services.

Telehealth means a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Covered Person's health care while the Covered Person is located at an originating site and the provider is located at a distant site. Remote monitoring means the use of synchronous or asynchronous technologies to collect or monitor medical and other forms of health data for individuals at an originating site and electronically that transmit that information to providers at a distant site so providers can assess, diagnose, consult, treat, educate, provide care management, suggest self-management, or make recommendations regarding a Covered Person's health care.

Terminally Ill means that a Covered Person's life expectancy, as determined by a Physician, is not greater than six months.

Urgent Care means non-life threatening medical and health services. Urgent Care services may be covered under the Group Policy the same as a Sickness or an Injury.

Urgent Care Center means a facility that meets all of the tests that follow:
1. It mainly provides urgent or emergency medical treatment for acute conditions;
2. It does not provide services or accommodations for overnight stays;
3. It is open to receive patients each day of a calendar year;
4. It has on duty at all times a Physician trained in emergency medicine and nurses and other supporting personnel who are specially trained in emergency care;
5. It has: x-ray and laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening events;
6. It has a written agreement with a local acute care hospital for the immediate transfer of patients who require greater care than can be furnished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care hospital that are immediate and reliable;
7. It complies with all licensing and other legal requirements.

Well-child Care Services means those preventive services and immunization services as set forth in the **BENEFITS/COVERAGE (What is Covered)** section of this Certificate. Services must be provided by a Physician or pursuant to Physician's supervision or by a primary health care provider who is a Physician's assistant or Registered Nurse, who has additional training in child health assessment and who is working in collaboration with a Physician.

Well-child Visit means a visit to a primary care provider that includes the following elements:
1. Age appropriate physical exam, but not a complete exam, unless the exam is age appropriate;
2. History;
3. Anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behavior, etc.);
4. Growth and development assessment, which also includes safety and health education counseling for other children.

You/Your refers to the Insured Employee who is enrolled for benefits under this health insurance plan**.**

Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from ”surprise billing”. This is sometimes called “balance billing” and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a ‘‘CO-DOI” on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan’s network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as “out-of-network”.

Out-of-network hospitals, facilities or providers often bill you the difference between what Kaiser Permanente Insurance Company (KPIC) decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called ‘surprise’ or ‘balance’ billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- KPIC will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- KPIC will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you do receive a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at 303-894-7490 or 1-800-9303745. **Ambulanc**e Information: You may be balance billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by KPIC, you may receive a balance bill.

Kaiser Permanente Insurance Company One Kaiser Plaza
Oakland, CA 94612
KPIC-GC-3TPOS-LG-2021-CO-NGF

Additional Information and Forms Applicable to Your Insurance Coverage

Please note the following pages are not part of the employer group insurance policy.

The following pages contain information we are required to provide you.

KAISER PERMANENTE
KAISER PERMANENTE INSURANCE COMPANY

PRIVACY NOTICE

Privacy Policy and Practices

This notice describes the privacy policy and practices regarding non-public personal information followed by Kaiser Permanente Insurance Company (herein referred to as "KPIC', "we", "us", and "our"). This notice is provided to you in compliance with the Gramm-Leach-Bliley Financial Services Modernization Act.

Collection of Non-public Personal Information

The types of non-public personal information that we may collect includes, but are not limited to:

- Information we receive from you as part of application forms, enrollment forms, claims forms, pre-certification/utilization reviews, etc, including, but not limited to, your name, address, sex, date of birth, Social Security number, martial status, dependents, and the identity of your employer.
- Information otherwise legally obtained by us, including information you authorize us to receive and/or resulting from your transactions with us, our affiliates, or non-affiliated third parties, including, but not limited to, medical information and claims history.

Disclosure of Non-public Personal Information

Unless otherwise authorized by you, KPIC will not disclose your non-public personal information except to affiliates and non-affiliates third parties as necessary to administer, underwrite, process, service, reinsure or market its own insurance products, or as necessary to effect, administer, or enforce a transaction authorized by you. When KPIC must release non-public personal information to non-affiliated third parties, as noted above, such third parties will subject to contractual agreements that require the third parties to maintain the confidentiality of such non-public personal information. If, at a future date, KPIC determines there is a need to share your non-public personal information with a non-affiliated third party, other than as described above, we will provide you with an advance opportunity to direct us not share such information.

KPIC may also disclose non-public personal information to authorized persons or entities to comply with: federal, state, or local laws, including any properly authorized civil, criminal, or regulatory investigation or subpoena or summons; or respond to judicial process or government regulatory authorities having jurisdiction over us for examination, compliance, or other purposes as authorized by law.

Non-public Personal Information Regarding Former Customers

Any non-public personal information KPIC maintains on former customers will be maintained on a confidential and secure basis. Any discosure of that information will only be made in keeping with the privacy policy and practices described in this notice or as otherwise permitted or required by law.

Confidentiality and Security of Non-public Personal Information

KPIC is committed to protecting the confidentiality and security of non-public personal information. In collaboration with our affiliates, we maintain physical, electronic, and procedural safeguards that comply with federal and state standards regarding the protection of such information. To insure that your information is not misused and is properly protected, KPIC has instituted the following:

- Employees are required to comply with our policies and procedures that exist to protect the confidentiality of customer information. Any employee who violates our privacy policy and practices is subject to a disciplinary process. Our policy requires medical records to be maintained in secure areas not accessible to the public.
- Employee access to information is provided on a business need-to-know basis such as: to facilitate administration, make benefit determinations, pay claims, managed care, underwrite coverage, or provide customer service.
- Mail and electronic security procedures to maintain confidentiality of the information we collect and to guard against its unauthorized access. Such methods include locked files, user authentication, encryption, and firewall technology.
- Contractual agreements with its non-affiliated third parties that require such third parties to maintain the confidentiality of non-public personal information.

Where to Write For More Information

If you have any questions about KPIC's privacy policy and practices, please write to the address listed below:

Kaiser Permanente Insurance Company
Attention: President
One Kaiser Plaza, 25 B
Oakland, California 94612

HIPAA Notice of Privacy Practices

KAISER PERMANENTE INSURANCE COMPANY ("KPIC")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this Notice we use the terms "we," "us" and "our" to describe KPIC.

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

Your protected health information ("PHI") is individually identifiable health information, including demographic information, about your past, present or future physical or mental health or condition, health care services you receive, and past, present or future payment for your health care. Demographic information means information such as your name, social security number, address, and date of birth.

PHI may be in oral, written or electronic form. Examples of PHI include your medical record, claims record, enrollment or disenrollment information, and communications between you and your health care provider about your care.

With the exception of those insured in California, your individually identifiable health information ceases to be PHI 50 years after your death.

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

1. protect the privacy of your PHI;
2. tell you about your rights and our legal duties with respect to your PHI;
3. notify you if there is a breach of your unsecured PHI; and
4. tell you about our privacy practices and follow our Notice currently in effect.

We take these responsibilities seriously, and have put in place administrative safeguards (such as security awareness training and policies and procedures), technical safeguards (such as encryption and passwords), and physical safeguards (such as locked areas and requiring badges) to protect your PHI and, as in the past, we will continue to take appropriate steps to safeguard the privacy of your PHI.

III. YOUR RIGHTS REGARDING YOUR PHI

This section tells you about your rights regarding your PHI, and describes how you can exercise these rights.

Your right to access and amend your PHI
Subject to certain exceptions, you have the right to view or get a copy of your PHI that we maintain in records relating to your care or decisions about your care or payment for your care. Requests must be in writing.

After we receive your written request, we will let you know when and how you can see or obtain a copy of your record. If you agree, we will give you a summary or explanation of your PHI instead of providing copies. We may charge you a fee for the copies, summary or explanation.

If we do not have the record you asked for but we know who does, we will tell you who to contact to request it. In limited situations, we may deny some or all of your request to see or receive copies of your records, but if we do, we will tell you why in writing and explain your right, if any, to have our denial reviewed.

If you believe there is a mistake in your PHI or that important information is missing, you may request that we correct or add to the record. Requests must be in writing, telling us what corrections or additions you are requesting, and why the corrections or additions should be made. We will respond in writing after reviewing your request. If we approve your request, we will make the correction or addition to your PHI. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement.

Submit all written requests to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to choose how we send PHI to you or someone else
You may ask us to send your PHI to you at a different address (for example, your work address) or by different means (for example, fax instead of regular mail).

If your PHI is stored electronically, you may request a copy of the records in an electronic format offered by KPIC. You may also make a specific written request to KPIC to transmit the electronic copy to a designated third party.

If the cost of meeting your request involves more than a reasonable amount, we are permitted to charge you our costs that exceeds that amount.

Your right to an accounting of disclosures of PHI
You may ask us for a list of our disclosures of your PHI. Write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

An accounting does not include certain disclosures, for example, disclosures:

- to carry out treatment, payment and health care operations;
- for which KPIC had a signed authorization;
- of your PHI to you;
- for notifications for disaster relief purposes;
- to persons involved in your care and persons acting on your behalf; or
- not covered by the right to an accounting.

Your right to request limits on uses and disclosures of your PHI
You may request that we limit our uses and disclosures of your PHI for treatment, payment and health care operations purposes. We will review and consider your request. You may write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to receive a paper copy of this Notice
You have a right to receive a paper copy of this Notice upon request.

IV. HOW WE MAY USE AND DISCLOSE YOUR PHI

Your confidentiality is important to us. Our employees are required to maintain the confidentiality of the PHI of our insureds and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We briefly describe these uses and disclosures below and give you some examples.

How much PHI is used or disclosed without your written permission will vary depending, for example, on the intended purpose of the use or disclosure. Sometimes we may only need to use or disclose a limited amount of PHI, such as to confirm that you are KPIC-insured. At other times, we may need to use or disclose more PHI such as when we assist in resolving an appeal or grievance.

- **Payment**: Your PHI may be needed to determine our responsibility to pay for, or to permit us to bill and collect payment for, treatment and health-related services that you receive. When you or a provider sends us the bill for health care services, we use and disclose your PHI to determine how much, if any, of the bill we are responsible for paying.

- **Health care operations**: We may use and disclose your PHI for certain health care operations, for example, quality assessment and improvement, licensing, accreditation, activities relating to the creation, renewal or replacement of health insurance or health benefits; conducting medical review; legal services; auditing functions, including fraud and abuse detection and compliance programs; customer service, underwriting, and determining premiums and other costs of providing health care.

- **Business associates**: We may contract with business associates to perform certain functions or activities on our behalf, such as payment and health care operations. These business associates must agree to safeguard your PHI.

- **Specific types of PHI**: There are stricter requirements for use and disclosure of some types of PHI, for example, mental health and drug and alcohol abuse patient information, mental health records, and HIV tests, and genetic testing information. However, there are still circumstances in which these types of information may be used or disclosed without your authorization.

- **Underwriting**: We may use and disclose your PHI, to the extent permitted under applicable law, for underwriting purposes, including the determination of benefit eligibility and costs of coverage and to perform other activities related to issuing a benefit policy. However, we are prohibited from using or disclosing your genetic information for underwriting purposes. Your genetic information includes information about your genetic tests, your family members' genetic tests, and requests for or receipt of genetic services by you or any family members.

- **Communications with family and others when you are present**: Sometimes a family member or other person involved in your care will be present when we are discussing your PHI with you. If you object, please tell us and we won't discuss your PHI or we will ask the person to leave.

- **Communications with family and others when you are not present**: There may be times when it is necessary to disclose your PHI to a family member or other

person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

- **Disclosure in case of disaster relief**: We may disclose your name, city of residence, age, gender, and general condition to a public or private disaster relief organization to assist disaster relief efforts, unless you object at the time.

- **Disclosures to parents as personal representatives of minors**: In most cases, we may disclose your minor child's PHI to you. In some situations, however, we are permitted or even required by law to deny your access to your minor child's PHI. Examples of when we must deny such access include your minor child's PHI regarding drug or addiction, certain mental health services, and venereal disease.

- **Public health activities**: Public health activities cover many functions performed or authorized by government agencies to promote and protect the public's health and may require us to disclose your PHI.

  - For example, we may disclose your PHI as part of our obligation to report to public health authorities certain diseases, injuries, conditions, and vital events such as births. Sometimes we may disclose your PHI to someone you may have exposed to a communicable disease or who may otherwise be at risk of getting or spreading the disease.
  - The Food and Drug Administration (FDA) is responsible for tracking and monitoring certain medical products, such as pacemakers and hip replacements, to identify product problems and failures and injuries they may have caused. If you have received one of these products, we may use and disclose your PHI to the FDA or other authorized persons or organizations, such as the maker of the product.
  - We may use and disclose your PHI as necessary to comply with federal and state laws that govern workplace safety.

- **Health oversight**: As a health insurer, we are subject to oversight conducted by federal and state agencies. These agencies may conduct audits of our operations and activities and in that process, they may review your PHI.

- **Disclosures to your employer or your employee organization**: If you are enrolled in a KPIC health insurance plan through your employer or employee organization, we may share certain PHI with them without your authorization, but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf. For other purposes, such as for

inquiries by your employer or employee organization on your behalf, we will obtain your authorization when necessary under applicable law.

- **Workers' compensation**: We may use and disclose your PHI in order to comply with workers' compensation laws. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.

- **Military activity and national security**: We may sometimes use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal officials as necessary for national security and intelligence activities or for protection of the President and other government officials and dignitaries.

- **Required by law**: In some circumstances federal or state law requires that we disclose your PHI to others. For example, the Secretary of the Department of Health and Human Services may review our compliance efforts, which may include seeing your PHI.

- **Lawsuits and other legal disputes**: We may use and disclose PHI in responding to a court or administrative order, a subpoena, or a discovery request. We may also use and disclose PHI to the extent permitted by law without your authorization, for example, to defend a lawsuit or arbitration.

- **Law enforcemen**t: We may disclose PHI to authorized officials for law enforcement purposes, for example, to respond to a search warrant, report a crime on our premises, or help identify or locate someone.

- **Abuse or neglect**: By law, we may disclose PHI to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.

- **Coroners and funeral directors**: We may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. We may also disclose PHI to funeral directors.

- **Inmates**: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their PHI as other individuals. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or the law enforcement official for certain purposes, for example, to protect your health or safety or someone else's.

V. ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

Except for those uses and disclosures described above, we will not use or disclose your PHI without your written authorization. Some instances in which we may request your authorization for use or disclosure of PHI are:

- **Marketing**: We may ask for your authorization in order to provide information about products and services that you may be interested in purchasing or using. Note that marketing communications do not include our contacting you with information about treatment alternatives, prescription drugs you are taking or health-related products or services that we offer or that are available only to our health plan enrollees. Marketing also does not include any face-to-face discussions you may have with your providers about products or services.
- **Sale of PHI**: We may only sell your PHI if we received your prior written authorization to do so.

When your authorization is required and you authorize us to use or disclose your PHI for some purpose, you may revoke that authorization by notifying us in writing at any time. Please note that the revocation will not apply to any authorized use or disclosure of your PHI that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health insurance from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

VI. HOW TO CONTACT US ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice, or want to lodge a complaint about our privacy practices, please let us know by calling or writing to:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You also may notify the Secretary of the Department of Health and Human Services (HHS).

We will not take retaliatory action against you if you file a complaint about our privacy practices.

VII. CHANGES TO THIS NOTICE

We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. If we make an important change to our privacy practices, we will promptly change this Notice and notify you via the U.S. Postal Service that the change has been made along with instructions for obtaining the new notice.

Except for changes required by law, we will not implement an important change to our privacy practices before we revise this Notice.

VIII. EFFECTIVE DATE OF THIS NOTICE

This Notice is effective on September 23, 2013.

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE COVERAGE

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (the Act) was passed into law on October 21, 1998. The law requires group and individual health plans that provide mastectomy coverage, such as your plan coverage, to also provide coverage for:

1. reconstruction of both the diseased and non-diseased breast to produce symmetrical appearance; and
2. prostheses and treatment of physical complications at all stages of the mastectomy, including lypmhademas.

The Kaiser Permanente Insurance Company plan under which you are insured provides coverage for mastectomy and includes the services listed above when performed following a covered mastectomy.

If you have any questions about the coverage provided under the Act and your plan of insurance, please do not hesitate to contact us at the number listed on your insurance card.

Kaiser Permanente
2500 S. Havana St.
Aurora, CO 80014-1622

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DENVER FIRE DEPARTMENT

KAISER PERMANENTE

Kaiser Permanente Insurance Company

000000074 082 ENAI IC PO GP [Mar.17,2021] OVC5OHOSPSEBLDHFMHOP5ESPVC6EOPTINCDOP5JHEARD9EMERCVPV2XAFTR7TACUMCLALG4EALGTNAAMBCVAUTBB1CDIP2HCDRR31CHIR4VCM
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C2C5OXYGINPNMT2HPP--REHBINREOPTZSGOPE3SNFINSNKR--STU--TABS2ETRANINTRGNCCTRVL--VADD--WLCH1PXPRO3BXRAY6BCDOP5JMHOP5EHEARD9SPVC6EOVC5ORX03HFBROK01DOMP0
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000000074 082 PV24 IC OP GP [Mar.17,2021] OVCV0HOSPT1BLDT8MHOP65SPVCWAOPTINCDOP45HEARH4EMERCVPV3EAFTR7UACUMCLALG4ZALGTNAAMBCVAUTBC4CDIP4HCDRR36CHIR--CM
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OVC2G2OXYGINPNMT4ZPP--REHBINREOP6ZSGOPCBSNFINSNKR--STU--TABS2VTRANINTRGN--TRVL--VADD--WLCH2YXPRO4ZXRAYH0CDOP45MHOP65HEARH4SPVCWAOVCV0RX03T8BROK01DOMP
01GREX01GRFD02OAD6MOAS6MSRDC05SV02WORAN

EXHIBIT A-13
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-13: City and County of Denver Civilian (75) Ratesheet.

Group Name: CITY AND COUNTY OF DENVER

Group Number: 75 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
075	C&C OF DENVER DHMO 500 ACT	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C75	C&C OF DENVER DHMO 500 CB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
R75	C&C OF DENVER DHMO500 PRE65 RT	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Steps	Total
Employee Only	$608.53
Spouse Only	$608.53
Child Only	$608.53
Employee & Spouse	$1,338.76
Employee & Child	$1,217.06
Spouse & Child	$1,217.06
Children Only (CK)	$1,217.06
Employee, Spouse & Child/Children	$1,947.29
Employee & Children (ECK+)	$1,217.06
Spouse & Children (SCK+)	$1,217.06
Children Only (CKK+)	$1,217.06

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: CITY AND COUNTY OF DENVER

Group Number: 75 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
075	C&C OF DENVER DHMO 500 ACT	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C75	C&C OF DENVER DHMO 500 CB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
R75	C&C OF DENVER DHMO500 PRE65 RT	Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Plan /ENTL	Total
Medicare Risk AB	$211.30
Medicare Risk B	$608.17
Medicare Risk BD	$608.17
Medicare Risk CD	$211.30

Group Name: CITY AND COUNTY OF DENVER

Group Number: 75 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
074	C&C OF DENVER HDHP 1450 ACT	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
C74	C&C OF DENVER HDHP 1450 CB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
R74	C&C OF DENVER HDHP1450 PR65 RT	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF

Steps	Total
Employee Only	$510.11
Spouse Only	$510.11
Child Only	$510.11
Employee & Spouse	$1,122.23
Employee & Child	$1,020.21
Spouse & Child	$1,020.21
Children Only (CK)	$1,020.21
Employee, Spouse & Child/Children	$1,632.07
Employee & Children (ECK+)	$1,020.21
Spouse & Children (SCK+)	$1,020.21
Children Only (CKK+)	$1,020.21

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: CITY AND COUNTY OF DENVER

Group Number: 75 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
074	C&C OF DENVER HDHP 1450 ACT	Medicare	EMAB	DED W/HSA 20% COIN M NGF
C74	C&C OF DENVER HDHP 1450 CB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
R74	C&C OF DENVER HDHP1450 PR65 RT	Medicare	EMAB	DED W/HSA 20% COIN M NGF

Plan /ENTL	Total
Medicare Risk AB	$211.30
Medicare Risk B	$608.17
Medicare Risk BD	$608.17
Medicare Risk CD	$211.30

Group Name: CITY AND COUNTY OF DENVER

Group Number: 75 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
C69	C&C OF DENVER HDHP 1450 CB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
R69	C&C OF DENVER HDHP1450 PR65 RT	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF

Steps	Total
Employee Only	$608.53
Spouse Only	$608.53
Child Only	$608.53
Employee & Spouse	$1,338.76
Employee & Child	$1,217.06
Spouse & Child	$1,217.06
Children Only (CK)	$1,217.06
Employee, Spouse & Child/Children	$1,947.29
Employee & Children (ECK+)	$1,217.06
Spouse & Children (SCK+)	$1,217.06
Children Only (CKK+)	$1,217.06

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: CITY AND COUNTY OF DENVER

Group Number: 75 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
C69	C&C OF DENVER HDHP 1450 CB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
R69	C&C OF DENVER HDHP1450 PR65 RT	Medicare	EMAB	DED W/HSA 20% COIN M NGF

Plan /ENTL	Total
Medicare Risk AB	$211.30
Medicare Risk B	$608.17
Medicare Risk BD	$608.17
Medicare Risk CD	$211.30

EXHIBIT A-14
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-14: City and County of Denver Police (68) Ratesheet.

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
085	DPD DHMO 500 ACTIVE	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C85	DPD DHMO 500 CB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C86	DPD DHMO 500 PRE 65 RET CB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C87	DPD DHMO 500 POST 65 RET CB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
R86	DPD DHMO 500 PRE 65 RET	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
R87	DPD DHMO 500 POST 65 RET	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Steps	Total
Employee Only	$523.98
Spouse Only	$523.98
Child Only	$523.98
Employee & Spouse	$1,152.82
Employee & Child	$1,047.98
Spouse & Child	$1,047.98
Children Only (CK)	$1,047.98
Employee, Spouse & Child/Children	$1,676.71
Employee & Children (ECK+)	$1,047.98
Spouse & Children (SCK+)	$1,047.98
Children Only (CKK+)	$1,047.98

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
085	DPD DHMO 500 ACTIVE	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C85	DPD DHMO 500 CB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C86	DPD DHMO 500 PRE 65 RET CB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
C87	DPD DHMO 500 POST 65 RET CB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
R86	DPD DHMO 500 PRE 65 RET	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
R87	DPD DHMO 500 POST 65 RET	Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Plan /ENTL	Total
Medicare Risk AB	$215.74
Medicare Risk B	$612.61
Medicare Risk BD	$612.61
Medicare Risk CD	$215.74

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
088	DPD HDHP 1450 ACTIVE	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
C88	DPD HDHP 1450 CB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
C89	DPD HDHP 1450 PRE 65 RET CB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
C90	DPD HDHP 1450 POST 65 RET CB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
R89	DPD HDHP 1450 PRE 65 RET	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
R90	DPD HDHP 1450 POST 65 RET	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF

Steps	Total
Employee Only	$487.45
Spouse Only	$487.45
Child Only	$487.45
Employee & Spouse	$1,067.86
Employee & Child	$970.62
Spouse & Child	$970.62
Children Only (CK)	$970.62
Employee, Spouse & Child/Children	$1,550.44
Employee & Children (ECK+)	$970.62
Spouse & Children (SCK+)	$970.62
Children Only (CKK+)	$970.62

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
088	DPD HDHP 1450 ACTIVE	Medicare	EMAB	DED W/HSA 20% COIN M NGF
C88	DPD HDHP 1450 CB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
C89	DPD HDHP 1450 PRE 65 RET CB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
C90	DPD HDHP 1450 POST 65 RET CB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
R89	DPD HDHP 1450 PRE 65 RET	Medicare	EMAB	DED W/HSA 20% COIN M NGF
R90	DPD HDHP 1450 POST 65 RET	Medicare	EMAB	DED W/HSA 20% COIN M NGF

Plan /ENTL	Total
Medicare Risk AB	$215.74
Medicare Risk B	$612.61
Medicare Risk BD	$612.61
Medicare Risk CD	$215.74

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
050	DPD HDHP 1450 DB/AC	Non Medicare	FILR	FILLER TIER 1
051	DPD HDHP 1450 DB/AC	Non Medicare	FILR	FILLER TIER 1
052	DPD HDHP 1450 DB/CB	Non Medicare	FILR	FILLER TIER 1
053	DPD HDHP PRE 65 RET DB/CB	Non Medicare	FILR	FILLER TIER 1
054	DPD HDHP RET POST 65 DB	Non Medicare	FILR	FILLER TIER 1

Steps	Total
Employee Only	$487.45
Spouse Only	$487.45
Child Only	$487.45
Employee & Spouse	$1,067.86
Employee & Child	$970.62
Spouse & Child	$970.62
Children Only (CK)	$970.62
Employee, Spouse & Child/Children	$1,550.44
Employee & Children (ECK+)	$970.62
Spouse & Children (SCK+)	$970.62
Children Only (CKK+)	$970.62

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
050	DPD HDHP 1450 DB/AC	Medicare	FILR	FILLER TIER 1
051	DPD HDHP 1450 DB/AC	Medicare	FILR	FILLER TIER 1
052	DPD HDHP 1450 DB/CB	Medicare	FILR	FILLER TIER 1
053	DPD HDHP PRE 65 RET DB/CB	Medicare	FILR	FILLER TIER 1
054	DPD HDHP RET POST 65 DB	Medicare	FILR	FILLER TIER 1

Plan /ENTL	Total
Medicare Risk AB	$215.74
Medicare Risk B	$612.61
Medicare Risk BD	$612.61
Medicare Risk CD	$215.74

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
032	DPD DHMO RET PRE 65 DB	Non Medicare	FILR	FILLER TIER 1

Steps	Total
Employee Only	$523.98
Spouse Only	$523.98
Child Only	$523.98
Employee & Spouse	$1,152.82
Employee & Child	$1,047.98
Spouse & Child	$1,047.98
Children Only (CK)	$1,047.98
Employee, Spouse & Child/Children	$1,676.71
Employee & Children (ECK+)	$1,047.98
Spouse & Children (SCK+)	$1,047.98
Children Only (CKK+)	$1,047.98

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER POLICE DEPARTMENT

Group Number: 68 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
032	DPD DHMO RET PRE 65 DB	Medicare	FILR	FILLER TIER 1

Plan /ENTL	Total
Medicare Risk AB	$215.74
Medicare Risk B	$612.61
Medicare Risk BD	$612.61
Medicare Risk CD	$215.74

EXHIBIT A-15
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-15: City and County of Denver Fire (74) Ratesheet.

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
087	DFD-RT-GOLD-PRE65-HDHP MEDC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
090	DFD-RT-GOLD-POS65-HDHP MEDC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
C87	DFD-RTCB-GOLD-PRE65-HDHP MEDC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
C90	DFD-RTCB-GOLD-POS65-HDHP MEDC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF

Steps	Total
Employee Only	$456.00
Spouse Only	$456.00
Child Only	$456.00
Employee & Spouse	$937.00
Employee & Child	$914.00
Spouse & Child	$914.00
Children Only (CK)	$914.00
Employee, Spouse & Child/Children	$1,319.00
Employee & Children (ECK+)	$914.00
Spouse & Children (SCK+)	$914.00
Children Only (CKK+)	$914.00

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
087	DFD-RT-GOLD-PRE65-HDHP MEDC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
090	DFD-RT-GOLD-POS65-HDHP MEDC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
C87	DFD-RTCB-GOLD-PRE65-HDHP MEDC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
C90	DFD-RTCB-GOLD-POS65-HDHP MEDC	Medicare	EMAB	DED W/HSA 20% COIN M NGF

Plan /ENTL	Total
Medicare Risk AB	$221.26
Medicare Risk B	$618.13
Medicare Risk BD	$618.13
Medicare Risk CD	$221.26

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
086	DFD-RT-GOLD-PRE65-HMO MEDC	Non Medicare	EMBD	$20 OVC HMO M NGF
089	DFD-RT-GOLD-POS65-HMO MEDC	Non Medicare	EMBD	$20 OVC HMO M NGF
091	DFD-RT-SILVER-POS65-HMO MEDC	Non Medicare	EMBD	$20 OVC HMO M NGF
092	DFD-RT-GOLD-PRE65 DEF PEN	Non Medicare	EMBD	$20 OVC HMO M NGF
093	DFD-RT-SILVER-PRE65 DEF PEN	Non Medicare	EMBD	$20 OVC HMO M NGF
C86	DFD-RTCB-GOLD-PRE65-HMO MEDC	Non Medicare	EMBD	$20 OVC HMO M NGF
C89	DFD-RTCB-GOLD-POS65-HMO MEDC	Non Medicare	EMBD	$20 OVC HMO M NGF
C91	DFD-RTCB-SILVER-POS65-HMO MEDC	Non Medicare	EMBD	$20 OVC HMO M NGF
C92	DFD-RTCB-GOLD-PRE65 DEF PEN	Non Medicare	EMBD	$20 OVC HMO M NGF
C93	DFD-RTCB-SILVER-PRE65 DEF PEN	Non Medicare	EMBD	$20 OVC HMO M NGF

Steps	Total
Employee Only	$615.00
Spouse Only	$615.00
Child Only	$615.00
Employee & Spouse	$1,258.00
Employee & Child	$1,227.00
Spouse & Child	$1,227.00
Children Only (CK)	$1,227.00
Employee, Spouse & Child/Children	$1,774.00
Employee & Children (ECK+)	$1,227.00
Spouse & Children (SCK+)	$1,227.00
Children Only (CKK+)	$1,227.00

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
086	DFD-RT-GOLD-PRE65-HMO MEDC	Medicare	EMBD	$20 OVC HMO M NGF
089	DFD-RT-GOLD-POS65-HMO MEDC	Medicare	EMBD	$20 OVC HMO M NGF
091	DFD-RT-SILVER-POS65-HMO MEDC	Medicare	EMBD	$20 OVC HMO M NGF
092	DFD-RT-GOLD-PRE65 DEF PEN	Medicare	EMBD	$20 OVC HMO M NGF
093	DFD-RT-SILVER-PRE65 DEF PEN	Medicare	EMBD	$20 OVC HMO M NGF
C86	DFD-RTCB-GOLD-PRE65-HMO MEDC	Medicare	EMBD	$20 OVC HMO M NGF
C89	DFD-RTCB-GOLD-POS65-HMO MEDC	Medicare	EMBD	$20 OVC HMO M NGF
C91	DFD-RTCB-SILVER-POS65-HMO MEDC	Medicare	EMBD	$20 OVC HMO M NGF
C92	DFD-RTCB-GOLD-PRE65 DEF PEN	Medicare	EMBD	$20 OVC HMO M NGF
C93	DFD-RTCB-SILVER-PRE65 DEF PEN	Medicare	EMBD	$20 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	$160.87
Medicare Risk AB	$221.26
Medicare Risk B	$557.74
Medicare Risk B	$618.13
Medicare Risk BD	$557.74
Medicare Risk BD	$618.13
Medicare Risk CD	$160.87
Medicare Risk CD	$221.26

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
080	DFD HMO AC	Non Medicare	ENAB	$20 OVC HMO NM NGF
088	DFD-RT-PRE65-HMO	Non Medicare	ENAB	$20 OVC HMO NM NGF
C80	DFD HMO CB	Non Medicare	ENAB	$20 OVC HMO NM NGF
C88	DFD-RTCB-PRE65-HMO	Non Medicare	ENAB	$20 OVC HMO NM NGF

Steps	Total
Employee Only	$615.00
Spouse Only	$615.00
Child Only	$615.00
Employee & Spouse	$1,258.00
Employee & Child	$1,227.00
Spouse & Child	$1,227.00
Children Only (CK)	$1,227.00
Employee, Spouse & Child/Children	$1,774.00
Employee & Children (ECK+)	$1,227.00
Spouse & Children (SCK+)	$1,227.00
Children Only (CKK+)	$1,227.00

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
082	DFD POS3 AC	Non Medicare	ENAB	$20 OVC HMO NM NGF
085	DFD-POS 3OPT-RET-PRE65	Non Medicare	ENAB	$20 OVC HMO NM NGF
C82	DFD POS3 CB	Non Medicare	ENAB	$20 OVC HMO NM NGF
C85	DFD-POS 3OPT-RETCB-PRE65	Non Medicare	ENAB	$20 OVC HMO NM NGF

Steps	Total
Employee Only	$747.00
Spouse Only	$747.00
Child Only	$747.00
Employee & Spouse	$1,531.00
Employee & Child	$1,493.00
Spouse & Child	$1,493.00
Children Only (CK)	$1,493.00
Employee, Spouse & Child/Children	$2,155.00
Employee & Children (ECK+)	$1,493.00
Spouse & Children (SCK+)	$1,493.00
Children Only (CKK+)	$1,493.00

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
081	DFD HDHP AC	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
C81	DFD HDHP CB	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF

Steps	Total
Employee Only	$456.00
Spouse Only	$456.00
Child Only	$456.00
Employee & Spouse	$937.00
Employee & Child	$914.00
Spouse & Child	$914.00
Children Only (CK)	$914.00
Employee, Spouse & Child/Children	$1,319.00
Employee & Children (ECK+)	$914.00
Spouse & Children (SCK+)	$914.00
Children Only (CKK+)	$914.00

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT

Group Number: 74 Contract Period: 01/01/2021 - 12/31/2021

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
083	DFD-OOA-PPO AC	Non Medicare	PV15	40% TRADTNL PPO - LG HCR
084	DFD 65 RT OOA	Non Medicare	PV15	40% TRADTNL PPO - LG HCR
C83	DFD-OOA-PPO CB	Non Medicare	PV15	40% TRADTNL PPO - LG HCR
C84	DFD 65 RTCB OOA	Non Medicare	PV15	40% TRADTNL PPO - LG HCR

Steps	Total
Employee Only	$747.00
Spouse Only	$747.00
Child Only	$747.00
Employee & Spouse	$1,531.00
Employee & Child	$1,493.00
Spouse & Child	$1,493.00
Children Only (CK)	$1,493.00
Employee, Spouse & Child/Children	$2,155.00
Employee & Children (ECK+)	$1,493.00
Spouse & Children (SCK+)	$1,493.00
Children Only (CKK+)	$1,493.00

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

EXHIBIT A-16
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-16: 2021 Performance Guarantees Agreement for Civilian Coverage.

KAISER PERMANENTE®

2021Performance Guarantees Agreement
City and County of Denver

Guaranteed Performance
This Performance Guarantees Agreement is effective from January 1, 2021 through December 31, 2021. We offer performance guarantees for our fully insured health plans backed by a percentage of your annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of your non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of your non-Medicare members will report performance without financial risk. In 2022, we will conduct a review of your 2021 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures
Some of our measures or targets may change year-to-year based on medical or public health trends, performance enhancements, new systems implementation and similar factors. In addition, some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA.) If the measure is no longer reported, the definition of a measure changes, or if there are changes to reporting rules or publications after these guarantees are in place, we may no longer guarantee the measure.

Penalty Thresholds and Reporting Frequency
To the extent possible, we set our penalty thresholds (i.e., the performance level we guarantee and below which we pay a penalty) in alignment with industry standards. Penalty thresholds for HEDIS measures are based on the applicable state/regional or national HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential
The information contained in this agreement is proprietary and confidential. Customer agrees to not share any information contained in this document with any Kaiser Permanente competitor, nor with any other third-party unless granted specific written consent to do so by Kaiser Permanente's representative.

Penalty Payments and Force Majeure
We report performance results based on our annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on the group's total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check. The group is responsible for notifying their account management team of the correct payment address to which payment should be sent when processed.

Penalty payments on sample-based measures are contingent on statistically significant differences ('margins of error') from penalty thresholds. If the result on a measure is below the penalty threshold (target) we use a standard statistical test to determine whether the difference is too large to be explained by random chance. We do not pay penalties unless the result is determined to be a true difference at the 95% or better confidence level.

If we are unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2021, in order to receive any penalty payments for missed performance measures due under this agreement. We require that Customer dispute any performance results and/or penalty due by submitting written notice to us within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Your written response must be received within 60 days of your receipt of our final report or you will forfeit any penalties otherwise due to you under this agreement.

Account Management Measures
Issues pertaining to satisfaction with account management are defined as matters that are under direct control of the Account Management Team (e.g. team availability, responses to customer questions, keeping customer informed of developments, etc.). Issues related to other health plan activities (e.g. pricing and rates, member call center services, claims, or eligibility processing) are not applicable to these measures and may be covered by other measures in this agreement.

Forfeiture on account management satisfaction measures is contingent on prompt notification (prior to September 1st of the agreement year) by the Customer of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of Kaiser Permanente account management to develop and execute on a corrective action plan constitutes failure on such measures.

To contact Kaiser Permanente
Thank you for giving us the opportunity to provide health care services to your employees and their families.
Please contact your Account Manager if you have questions or comments concerning this agreement.

KAISER PERMANENTE®

2021Performance Guarantees Agreement

City and County of Denver

Based on projected 2021 membership, we expect the **Colorado** region will be guaranteed with premium at risk.

This Performance Guarantees Agreement is effective from January 1, 2021 through December 31, 2021.
Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except on measures where the penalty threshold is shown with a decimal point (e.g. ≤3.0%)

2021 Performance Measures		Penalty Threshold	Penalty (% of Premium)
Implementation, Administration and Account Management			
1.	**City and County of Denver** – clean eligibility files initial upload completed within 2 business days of receipt when file is received prior to 2:15 pm MST	93%	0.10%
2.	Premium reconciliation within 30 calendar days (% of PG groups)	85%	0.10%
3.	Identification card distribution – percent within 10 business days of receipt (% of PG Groups)	95%	0.10%
4.	Provide contract / booklet updated within 60 days	Provide	0.09%
5.	Customer overall satisfaction with account management/team	Purchaser satisfied; see provisions on cover page	0.10%
6.	Quarterly operational performance reporting provided 60 days after the end of each quarter.	Provide	0.09%
Member Services			
6.	Member service calls answered within 30 seconds	80%	0.10%
7.	Telephone call abandonment rate	≤ 3.0%	0.10%
8.	First contact resolution (includes emails, same member / same issue call back within 30	80%	0.10%
Member Satisfaction			
9.	Member satisfaction with health plan (CAHPS #42)[1]	≥ State Avg. [2]*	0.10%
Claims			
10.	Claims financial accuracy	98.5%	0.10%
11.	Claims processing (financial incident) accuracy	97%	0.10%
12.	Claims processing turnaround within 30 calendar days (clean claims)	95%	0.10%
Quality of Care			
13.	BMI – Adult BMI Assessment	≥ Natl. Avg. [3]*	0.08%
14.	Weight Assessment & Counseling Children/Adolescents – Nutrition	≥ Natl. Avg. [3]*	0.08%
15.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. Avg. [3]*	0.08%
16.	Statin Therapy for Patients with Cardiovascular Disease (Total)	≥ Natl. Avg. [3]*	0.08%
17.	Colorectal Cancer Screening Rate	≥ Natl. Avg. [3]*	0.08%
18.	Mammography Screening Rate	≥ Natl. Avg. [3]*	0.08%
19.	Follow-up After Mental Illness (7 days)	≥ Natl. Avg. [3]*	0.08%
20.	Diabetes – Controlling High Blood Pressure (140/90)	≥ Natl. Avg. [3]*	0.08%
21.	Diabetes – Glycemic Poor Control Rate	≥ Natl. Avg. [3]*	0.08%
Total Percent at Risk			*2.00 %*

[1] From the NCQA CAHPS Survey, based on the percent of respondents answering eight or higher on a 0 - 10 scale
[2] Based on NCQA's State/Regional HMO Average
[3] Based on NCQA's National HMO Average
* Penalties are contingent on statistically significant differences from targets

EXHIBIT A-17
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-17: 2021 Performance Guarantees Agreement for Police Coverage.

KAISER PERMANENTE®

2021 Performance Guarantees Agreement
Denver Police Department

Guaranteed Performance
This Performance Guarantees Agreement is effective from January 1, 2021 through December 31, 2021. We offer performance guarantees for our fully-insured health plans backed by a percentage of your annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of your non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of your non-Medicare members will report performance without financial risk. In 2022, we will conduct a review of your 2021 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures
Some of our measures or targets may change year-to-year based on medical or public health trends, performance enhancements, new systems implementation and similar factors. In addition, some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA.) If the measure is no longer reported, the definition of a measure changes, or if there are changes to reporting rules or publications after these guarantees are in place we may no longer guarantee the measure.

Penalty Thresholds and Reporting Frequency
To the extent possible, we set our penalty thresholds (i.e., the performance level we guarantee and below which we pay a penalty) in alignment with industry standards. Penalty thresholds for HEDIS measures are based on the applicable state/regional or national HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential
The information contained in this agreement is proprietary and confidential. Customer agrees to not share any information contained in this document with any Kaiser Permanente competitor, nor with any other third-party unless granted specific written consent to do so by Kaiser Permanente's representative.

Penalty Payments and Force Majeure
We report performance results based on our annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on the group's total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check. The group is responsible for notifying their account management team of the correct payment address to which payment should be sent when processed.

Penalty payments on sample-based measures are contingent on statistically significant differences ('margins of error') from penalty thresholds. If the result on a measure is below the penalty threshold (target) we use a standard statistical test to determine whether the difference is too large to be explained by random chance. We do not pay penalties unless the result is determined to be a true difference at the 95% or better confidence level.

If we are unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2021, in order to receive any penalty payments for missed performance measures due under this agreement. We require that Customer dispute any performance results and/or penalty due by submitting written notice to us within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Your written response must be received within 60 days of your receipt of our final report or you will forfeit any penalties otherwise due to you under this agreement.

Account Management Measures
Issues pertaining to satisfaction with account management are defined as matters that are under direct control of the Account Management Team (e.g. team availability, responses to customer questions, keeping customer informed of developments, etc.). Issues related to other health plan activities (e.g. pricing and rates, member call center services, claims, or eligibility processing) are not applicable to these measures and may be covered by other measures in this agreement.

Forfeiture on account management satisfaction measures is contingent on prompt notification (prior to September 1st of the agreement year) by the Customer of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of Kaiser Permanente account management to develop and execute on a corrective action plan constitutes failure on such measures.

To contact Kaiser Permanente
Thank you for giving us the opportunity to provide health care services to your employees and their families.
Please contact your Account Manager if you have questions or comments concerning this agreement.

KAISER PERMANENTE®

2021 Performance Guarantees Agreement

Denver Police Department

Based on projected 2021 **membership**, we expect these health plans will be **guaranteed** with premium at risk:
Colorado

This Performance Guarantees Agreement is effective from January 1, 2021 through December 31, 2021.
Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except on measures where the penalty threshold is shown with a decimal point (e.g. ≤3.0%)

2021 Performance Measures		Penalty Threshold	Penalty (% of Premium)
Member Services			
1.	Member Services calls answered within 30 seconds	80%	0.10%
2.	Telephone call abandonment rate	≤ 3.0%	0.10%
3.	Eligibility information accessible to medical groups within eight business days (% of PG groups)	95%	0.11%
4.	ID card processing within10 business days (% of PG groups)	95%	0.11%
5.	Premium/Eligibility reconciliation within 30 calendar days (% of PG groups)[1]	85%	0.11%
6.	Kp.org Web site availability	98.5%	0.12%
Account Management			
7.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.12%
Member Satisfaction and Access			
8.	Overall Satisfaction with health plan (NCQA: Q#42-%8-10)[2]	≥ State Avg.[3]*	0.12%
9.	Satisfaction with Customer Service Composite (NCQA: Q#35 & #36 - % usually or always)	≥ State Avg.[3]*	0.12%
10.	Easy to Get Care, Tests or Treatment you Thought you Needed (NCQA: Q#14 – % usually or always)	≥ State Avg.[3]*	0.12%
Quality (HEDIS Effectiveness of Care)			
11.	Diabetes – Controlling High Blood Pressure	≥ Natl. Avg.[4]*	0.12%
12.	Colorectal Cancer Screening Rate	≥ Natl. Avg.[4]*	0.10%
13.	Statin Therapy for Patients with Cardiovascular Disease	≥ Natl. Avg.[4]*	0.10%
14.	Asthma Medication Ratio	≥ Natl. Avg.[4]*	0.11%
15.	Persistence of Beta Blocker Treatment after Heart Attack	≥ Natl. Avg.[4]*	0.11%
16.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. Avg.[4]*	0.11%
17.	Cervical Cancer Screening Rate	≥ Natl. Avg.[4]*	0.11%
18.	Asthma Medication Ratio	≥ Natl. Avg.[4]*	0.11%
		Total Percent at Risk	*2.00 %*

[1] The 30-day calendar starts the day Kaiser Permanente has received both the premium and the premium report.
[2] From the NCQA CAHPS Survey, based on the percent of respondents answering eight or higher on a 0 - 10 scale
[3] Based on NCQA's State/Regional HMO Average
[4] Based on NCQA's National HMO Average
* Penalties are contingent on statistically meaningful differences from targets

EXHIBIT A-18
TO 2021 AGREEMENT WITH
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-18: 2021 Performance Guarantees Agreement for Fire Coverage.

KAISER PERMANENTE®

2021 Performance Guarantees Agreement
Denver Fire Department

Guaranteed Performance
This Performance Guarantees Agreement is effective from January 1, 2021 through December 31, 2021. We offer performance guarantees for our fully-insured health plans backed by a percentage of your annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of your non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of your non-Medicare members will report performance without financial risk. In 2022, we will conduct a review of your 2021 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures
Some of our measures or targets may change year-to-year based on medical or public health trends, performance enhancements, new systems implementation and similar factors. In addition, some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA.) If the measure is no longer reported, the definition of a measure changes, or if there are changes to reporting rules or publications after these guarantees are in place we may no longer guarantee the measure.

Penalty Thresholds and Reporting Frequency
To the extent possible, we set our penalty thresholds (i.e., the performance level we guarantee and below which we pay a penalty) in alignment with industry standards. Penalty thresholds for HEDIS measures are based on the applicable state/regional or national HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential
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Penalty Payments and Force Majeure
We report performance results based on our annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on the group's total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check. The group is responsible for notifying their account management team of the correct payment address to which payment should be sent when processed.

Penalty payments on sample-based measures are contingent on statistically significant differences ('margins of error') from penalty thresholds. If the result on a measure is below the penalty threshold (target) we use a standard statistical test to determine whether the difference is too large to be explained by random chance. We do not pay penalties unless the result is determined to be a true difference at the 95% or better confidence level.

If we are unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2021, in order to receive any penalty payments for missed performance measures due under this agreement. We require that Customer dispute any performance results and/or penalty due by submitting written notice to us within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Your written response must be received within 60 days of your receipt of our final report or you will forfeit any penalties otherwise due to you under this agreement.

Account Management Measures
Issues pertaining to satisfaction with account management are defined as matters that are under direct control of the Account Management Team (e.g. team availability, responses to customer questions, keeping customer informed of developments, etc.). Issues related to other health plan activities (e.g. pricing and rates, member call center services, claims, or eligibility processing) are not applicable to these measures and may be covered by other measures in this agreement.

Forfeiture on account management satisfaction measures is contingent on prompt notification (prior to September 1st of the agreement year) by the Customer of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of Kaiser Permanente account management to develop and execute on a corrective action plan constitutes failure on such measures.

To contact Kaiser Permanente
Thank you for giving us the opportunity to provide health care services to your employees and their families.
Please contact your Account Manager if you have questions or comments concerning this agreement.

KAISER PERMANENTE®

2021 Performance Guarantees Agreement

Denver Fire Department

Based on projected 2021 membership, we expect these health plans will be guaranteed with premium at risk:
Colorado

This Performance Guarantees Agreement is effective from January 1, 2021 through December 31, 2021.
Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except on measures where the penalty threshold is shown with a decimal point (e.g. ≤3.0%)

2021 Performance Measures		Penalty Threshold	Penalty (% of Premium)
Member Services			
1.	Member Services calls answered within 30 seconds	80%	0.10%
2.	Telephone call abandonment rate	≤ 3.0%	0.10%
3.	ID card processing within 10 business days (% of PG groups)	95%	0.11%
4.	Eligibility information accessible to medical groups within eight business days (% of PG groups)	95%	0.11%
5.	Premium/Eligibility reconciliation within 30 calendar days (% of PG groups)[1]	85%	0.11%
6.	Kp.org Web site availability	98.5%	0.12%
Account Management			
7.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.12%
Member Satisfaction			
8.	Overall Satisfaction with health plan (NCQA: Q#42-%8-10)[2]	≥ State Avg.[3]*	0.12%
9.	Satisfaction with Customer Service Composite (NCQA: Q#35 & #36 - % usually or always)	≥ State Avg.[3]*	0.12%
10.	Easy to Get Care, Tests or Treatment you Thought you Needed (NCQA: Q#14 – % usually or always)	≥ State Avg.[3]*	0.12%
Quality of Care			
11.	Diabetes – Controlling High Blood Pressure (140/90)	≥ Natl. Avg.[4]*	0.12%
12.	Colorectal Cancer Screening Rate	≥ Natl. Avg.[4]*	0.10%
13.	Statin Therapy for Patients with Cardiovascular Disease	≥ Natl. Avg.[4]*	0.10%
14.	Asthma Medication Ratio	≥ Natl. Avg.[4]*	0.11%
15.	Persistence of Beta Blocker Treatment after Heart Attack	≥ Natl. Avg.[4]*	0.11%
16.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. Avg.[4]*	0.11%
17.	Childhood Immunization (Combination 10)	≥ Natl. Avg.[4]*	0.11%
18.	Cervical Cancer Rate	≥ Natl. Avg.[4]*	0.11%
		Total Percent at Risk	*2.00 %*

[1] The 30-day calendar starts the day Kaiser Permanente has received both the premium and the premium report.
[2] From the NCQA CAHPS Survey, based on the percent of respondents answering eight or higher on a 0 - 10 scale
[3] Based on NCQA's State/Regional HMO Average
[4] Based on NCQA's National HMO Average
* Penalties are contingent on statistically meaningful differences from targets