



KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2018
LARGE GROUP
GROUP AGREEMENT

City and County of Denver
Denver Fire Department
Denver Police Department

GROUP AGREEMENT

THIS AGREEMENT to purchase the attached insurance 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” or “Insurance Company” and together the “parties”).

The parties agree as follows:

INTRODUCTION

For each Group, this Group Agreement (“*Agreement*”), including the Rate Sheet(s), the Summary of Benefits and Coverage (“SBC”), Underwriting Assumptions and Requirements document, the Performance Guarantees document, and the Evidences of Coverage (“EOC”) (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”).

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 accord with the attached *Evidence of Coverage* documents. The insurance policy being purchased by the City has been by the Colorado Division of Insurance (“DOI”). Health Plan will provide Group with all internal policies with affect Member coverage under this *Agreement*. These policies will be disclosed to Group prior to the effective date of this *Agreement*.

If Group does not renew this *Agreement*, Group must give Health Plan written notice as described in the “Termination of *Agreement*” section.

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 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 (attached as Exhibits B, and B-1), 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 allowed in each program description attached. Documents related to the Health Plan Wellness Programs (attached hereto in Exhibit B) are:

1. Workforce Health Package Letter,
2. Workforce Health Programs Document,
3. "Weigh and Win" program through an agreement with Incentahealth, LLC (Denver Contract #CSAHR-20162635.00) (not attached).

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, Insurance Company agrees to pay \$200,000 to the workplace wellness software provider Viverae, Inc., for the purchase and implementation of a wellness platform software that the City will maintain. Such payment will be paid in full to Viverae, Inc. no more than 30 days after invoicing. Insurance Company 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 insurance premiums.

COORDINATION OF POLICY PURCHASE AND SIGNATURE AUTHORIZATION

The Insurance Company shall fully coordinate the purchase of agreed policies with the Executive Director. The Executive Director, or Executive Director's designee, shall be authorized to sign the documents listed in Exhibits A and B, attached hereto, and any other policy or wellness-related documents necessary for implementation or administration of the City's insurance program.

TERM OF AGREEMENT and RENEWAL

Term of Agreement

This *Agreement* is effective for the term beginning January 1, 2018, and ending at 11:59 p.m. on December 31, 2018, 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* either by sending Group a new *Agreement* to become effective immediately after termination of this *Agreement*, or by offering to extend the term of this *Agreement* pursuant to "Amendments Effective on an Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended *Agreement* will include a new term of *Agreement* and other changes that are mutually agreed upon in writing by Health Plan and Group.

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, 2018 (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 the Medicare Part D initial and catastrophic coverage levels; 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*, 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 Dues, 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 Dues, 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 Dues 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 Dues through the termination date. In the event that any Dues payment is not timely received by Health Plan, Health Plan will send the Group a notice of Dues owed. Such notice shall specify the delinquent Dues 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 Dues 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 Dues 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.

DUES

Only Members for whom Health Plan has received the appropriate Dues 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 Dues by the first of the coverage month or by the date otherwise agreed to by Health Plan and Group, the Dues may include an additional administrative charge upon renewal. "Full Dues" means 100 percent of monthly Dues for each enrolled Member, as set forth in this "Dues" section.

Dues Rebates

If state or federal law requires Health Plan to rebate dues from this or any earlier contract year and Health Plan rebates dues 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

Dues 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, dues 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; or
- 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.

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 Dues 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 Dues 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 Dues 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).
- Meet all Health Plan requirements set forth in the “Underwriting Assumptions and Requirements” document, included in Exhibit A.
- 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.

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*.

Insurance Company 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.

INDEMNIFICATION

Health Plan agrees to defend, release, indemnify and save and hold harmless the City, and its agents, officers and employees acting in their capacity as agents of the City against any and all claims, demands, costs (including reasonable attorney's fees) suits, actions, liabilities, causes of action or legal or equitable proceedings of any kind or nature, including workers' compensation claims, of or by anyone whomsoever, to the extent that they arise out of Health Plan's acts or omissions under this *Agreement*, including acts or omissions of Health Plan or to the extent that they are acting in their capacity as agents of Health Plan, its officers, employees, representatives, suppliers, invitees, licensees, subconsultants, subcontractors, and agents; provided, however, that Health Plan need not indemnify and save harmless the City, its officers, agents, and employees from damages arising out of the sole negligence of the City or the City's officers, agents, and employees acting in their capacity as agents of the City. This indemnity clause shall also cover the City's defense costs, in the event that the City, in its sole discretion, except as provided below, elects to provide its own defense. To the extent there is not a conflict, the City shall tender to Health Plan the opportunity, at Health Plan's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If Health Plan accepts the tender, then Health Plan shall have no obligation to the City with respect to attorney's fees incurred by the City relating to the claim. Upon request, the City shall provide Health Plan all information and assistance reasonably necessary for the defense of the claim. In the event of a conflict and insurance counsel is needed, Health Plan will pay for separate counsel for the City. The City will select insurance counsel that normally or routinely works on insurance matters, and Health Plan may propose a list containing at least three (3) counsel alternatives from which the City may select.

PERFORMANCE GUARANTEES

The Performance Guarantees as set forth in the attached Performance Guarantees document included in **Exhibit A**, are expressly incorporated into 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.

Note: Group and Health 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* 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.

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 of 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 of 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

2018 Kaiser Foundation Health Plan of Colorado

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.

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.

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*.

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.

No Waiver

Health Plan's failure and Group's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's or Group's right thereafter to require strict performance of any provision.

Notices

Notices must be delivered in writing to the address 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 of Human Resources
201 W. Colfax Ave., Dept. 412
Denver, CO 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 a Group a written request, Group will send Health Plan a list of all Members covered under this Group 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 be invalid.

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 Dues, collectively, shall not exceed **EIGHTY-FOUR MILLION, ONE HUNDRED TWENTY-FIVE THOUSAND AND 00/100 DOLLARS \$84,125,000.00** 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 Dues 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 Dues 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 Illegal Aliens 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, as may be amended from time to time (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 an illegal alien who will perform work under this Agreement, 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 an illegal alien to perform work under the Agreement;
- (2) shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Consultant that it shall not knowingly employ or contract with an illegal alien 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 subconsultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal

alien, 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 the illegal alien, 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 an illegal alien, 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 Consultant from submitting bids or proposals for future contracts with the City.

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 ((720) 913-1633, denvermarketingoffice@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. Health Plan shall display the Denver Logo in a read-only format and shall not be used or displayed on the website in any format from which it can be downloaded, copied or reproduced in any manner. The license granted by the City is non-transferable and non-assignable to anyone other than those acting under the supervision and authority of Health Plan.

Health Plan shall be solely responsible for the entire cost and expense of Health Plan’s Use of the Denver Logo. The Denver Logo may not be used as a feature or design element of any other logo or graphic. Health Plan shall use the Denver Logo in accordance with any and all logo usage guidelines in effect from time-to-time as provided by the City. Health Plan shall use only accurate reproductions of the Denver Logo. The size, proportions, colors, elements, and other distinctive characteristics of the Denver Logo shall not be altered in any manner except as may be permitted herein or as permitted in writing by the City. Health Plan may use the colors set forth in the “Denver Logo Colors” document, (attached hereto as “**Exhibit C**”).

Health Plan shall affix a trademark (“™”) or registration (“®”) indication next to the Denver Logo as directed by the Denver Marketing Office. Health Plan shall immediately cease all use of the Denver Logo upon expiration of the Term of this Agreement, as may have been extended from time to time by the parties, in a formal written extension of this Agreement.

Exhibit List:

Exhibit A - EOC Brochure, Summary of Benefits and Coverage & Performance Guarantees

Exhibit B - Wellness Programs

Exhibit C - Denver Logo Guidelines

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

[The City's Contract System Will Produce Signature Blocks to be Inserted]

Contract Control Number:

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:

REGISTERED AND COUNTERSIGNED:

By _____


By _____

By _____



Contract Control Number: CSAHR-201736840-00

Contractor Name: Kaiser Permanente Insurance Company

By: 

Name: R. Roland Lyon
(please print)

Title: President
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)



EXHIBIT A

KAISER FOUNDATION HEALTH PLAN

OF COLORADO

Summary of Benefits and Coverage

Underwriting Assumptions

Performance Guarantees

Evidences of Coverage (EOC)

EXHIBIT A

Summaries of Benefits and Coverage

- 1. City & County of Denver DHMO 500**
- 2. City & County of Denver HDHP 1350**
- 3. Denver Police Department DHMO 500**
- 4. Denver Police Department HDHP 1350**
- 5. Denver Fire Department Active HMO 220**
- 6. Denver Fire Department HDHP 1500 Active**
- 7. Denver Fire Department PPO**
- 8. Denver Fire Department Active POS**

EXHIBIT A

Summaries of Benefits and Coverage

City & County of Denver DHMO 500



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 Individual / \$1,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes, preventive services , certain services with copays, prescription drugs and hospice	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	\$3,000 Individual / \$6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Copay not subject to deductible .
	Specialist visit	\$50 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Copay not subject to deductible .
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Not subject to deductible .
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: No Charge	Not Covered	Diagnostic lab services: not subject to the deductible except when provided in the outpatient department of a hospital; 20% Coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$20 Copay; Mail Order: \$40 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$40 Copay; Mail Order: \$80 Copay	Not Covered	
	Non-preferred brand drugs	Retail: \$60 Copay; Mail Order: \$120 Copay	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., ambulatory surgery center)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$200 Copay per visit	\$200 Copay per visit	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted directly to the hospital as an inpatient. Copay not subject to deductible .
	Emergency medical transportation	20% Coinsurance up to \$500	20% Coinsurance up to \$500	Not subject to deductible . or None
	Urgent care	\$75 Copay per visit; 20% Coinsurance for covered services received during a visit.	\$75 Copay per visit; 20% Coinsurance for covered services received during a visit.	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to deductible .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., hospital room)	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Group visit 50% of individual visit copay. Copay not subject to deductible .
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: \$30 Copay per visit	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible .
	Habilitation services	\$30 Copay per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible .
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance. Not subject to deductible .
	Hospice services	No Charge	Not Covered	Not subject to deductible .
If your child needs dental or eye care	Children's eye exam	\$30 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	For services with an ophthalmologist see "Specialist visit". Copay not subject to deductible .
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Acupuncture • • • Cosmetic Surgery • Hearing aids with limits (Adults) | <ul style="list-style-type: none"> • • Long Term Care/Custodial Nursing Home Care • Non-emergency care when traveling outside the U.S. • Routine Dental Services | <ul style="list-style-type: none"> • • Routine Foot Care • Weight Loss Programs |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care • Hearing aids with limits | <ul style="list-style-type: none"> • Infertility treatment • Private-Duty Nursing • Routine eye care |
|--|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [copay] \$50
- Hospital (facility) [coinsurance] 20%
- Other [coinsurance] 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,800

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [copay] \$50
- Hospital (facility) [coinsurance] 20%
- Other [coinsurance] 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,360

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [copay] \$50
- Hospital (facility) [coinsurance] 20%
- Other [coinsurance] 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$30
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$630

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል፡ 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò b̀éìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	City and County of Denver DHMO 500
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.</p>
5. Out-of-Pocket Maximum	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>

6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments for Essential Health Benefits.
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

EXHIBIT A

Summaries of Benefits and Coverage

City & County of Denver HDHP 1350



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,350 Individual / \$2,700 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes, preventive services .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	\$2,700 Individual/ \$5,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limits must be met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	Not Covered	None
	Specialist visit	20% Coinsurance	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Not subject to deductible .
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: 20% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$10 Copay; Mail Order: \$20 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$35 Copay; Mail Order: \$70 Copay	Not Covered	
	Non-preferred brand drugs	Retail: \$60 Copay; Mail Order: \$120 Copay	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	20% Coinsurance	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	Not Covered	None
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: 20% Coinsurance	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Habilitation services	20% Coinsurance	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance.
	Hospice services	20% Coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	Not Covered	For services with an ophthalmologist see "Specialist visit".
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic Surgery Hearing aids with limits (Adults) 	<ul style="list-style-type: none"> Infertility treatment Long Term Care/Custodial Nursing Home Care Non-emergency care when traveling outside the U.S. Routine Dental Services (Adult) 	<ul style="list-style-type: none"> Routine Foot Care Weight Loss Programs 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Chiropractic care Hearing aids with limits 	<ul style="list-style-type: none"> Private-Duty Nursing Routine eye care 	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits

Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,810

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$400
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,210

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,450

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò bèìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	City and County of Denver HDHP 1350
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>AGGREGATE DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.</p>
5. Out-of-Pocket Maximum	<p>AGGREGATE OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.</p>

6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

EXHIBIT A

Summaries of Benefits and Coverage

Denver Police Department DHMO 500



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 Individual / \$1,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes, preventive services , certain services with copays, prescription drugs and hospice	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	\$3,000 Individual / \$6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Copay not subject to deductible .
	Specialist visit	\$50 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Copay not subject to deductible .
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Not subject to deductible .
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: No Charge	Not Covered	Diagnostic lab services: not subject to the deductible except when provided in the outpatient department of a hospital; 20% Coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$20 Copay; Mail Order: \$40 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$40 Copay; Mail Order: \$80 Copay	Not Covered	
	Non-preferred brand drugs	Retail: \$60 Copay; Mail Order: \$120 Copay	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., ambulatory surgery center)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$200 Copay per visit	\$200 Copay per visit	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted directly to the hospital as an inpatient. Copay not subject to deductible
	Emergency medical transportation	20% Coinsurance up to \$500	20% Coinsurance up to \$500	Not subject to deductible .
	Urgent care	\$75 Copay per visit; 20% Coinsurance for covered services received during a visit.	\$75 Copay per visit; 20% Coinsurance for covered services received during a visit.	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to deductible .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., hospital room)	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	Group visit 50% of individual visit copay. Copay not subject to deductible .
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: \$30 Copay per visit	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible .
	Habilitation services	\$30 Copay per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copay not subject to deductible .
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance. Not subject to deductible
	Hospice services	No Charge	Not Covered	Not subject to deductible .
If your child needs dental or eye care	Children's eye exam	\$30 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered	For services with an ophthalmologist see "Specialist visit". Copay not subject to deductible .
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Acupuncture • • • Cosmetic Surgery • Hearing aids with limits (Adults) | <ul style="list-style-type: none"> • • Long Term Care/Custodial Nursing Home Care • Non-emergency care when traveling outside the U.S. • Routine Dental Services | <ul style="list-style-type: none"> • • Routine Foot Care • Weight Loss Programs |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care • Hearing aids with limits | <ul style="list-style-type: none"> • Infertility treatment • Private-Duty Nursing • Routine eye care |
|--|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist \[copay\]](#) \$50
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,800

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist \[copay\]](#) \$50
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,360

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist \[copay\]](#) \$50
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò b̀éìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Police Department DHMO 500
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.</p>
5. Out-of-Pocket Maximum	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>

6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments for Essential Health Benefits.
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

EXHIBIT A

Summaries of Benefits and Coverage

Denver Police Department HDHP 1350



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,350 Individual / \$2,700 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes, preventive services .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	\$2,700 Individual/ \$5,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limits must be met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	Not Covered	None
	Specialist visit	20% Coinsurance	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Not subject to deductible .
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: 20% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$10 Copay; Mail Order: \$20 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$35 Copay; Mail Order: \$70 Copay	Not Covered	
	Non-preferred brand drugs	Retail: \$60 Copay; Mail Order: \$120 Copay	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	20% Coinsurance	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	Not Covered	None
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: 20% Coinsurance	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Habilitation services	20% Coinsurance	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance.
	Hospice services	20% Coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	Not Covered	For services with an ophthalmologist see "Specialist visit".
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic Surgery Hearing aids with limits (Adults) 	<ul style="list-style-type: none"> Infertility treatment Long Term Care/Custodial Nursing Home Care Non-emergency care when traveling outside the U.S. Routine Dental Services (Adult) 	<ul style="list-style-type: none"> Routine Foot Care Weight Loss Programs 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Chiropractic care Hearing aids with limits 	<ul style="list-style-type: none"> Private-Duty Nursing Routine eye care 	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits

Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,810

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$400
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,110

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,450

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò b̀éìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áá jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Police Department HDHP 1350
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>AGGREGATE DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.</p>
5. Out-of-Pocket Maximum	<p>AGGREGATE OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.</p>

6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
 Denver/Boulder: 1-303-338-3820


If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us


EXHIBIT A

Summaries of Benefits and Coverage

Denver Fire Department Active HMO 220

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1- 855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Not Applicable	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	\$2,000 Individual / \$4,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copay per visit	Not Covered	None
	Specialist visit	\$30 Copay per visit	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge Lab: No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 Copay per test	Not Covered	Multiple cost shares may apply per encounter.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$15 Copay; Mail Order: \$30 Copay	Not Covered	Subject to formulary guidelines. Non-preferred brand drugs: except those prescribed and authorized through the non-preferred drug process (subject to the brand copay). Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$30 Copay; Mail Order: \$60 Copay	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 Copay	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., hospital room)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 Copay per visit	\$100 Copay per visit	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% Coinsurance up to \$500	20% Coinsurance up to \$500	None
	Urgent care	\$50 Copay per visit	\$50 Copay per visit	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 Copay per admission	Not Covered	None
	Physician/surgeon fees	See Facility fee (e.g., hospital room)	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay per visit	Not Covered	Group visit 50% of individual visit copay.
	Inpatient services	\$750 Copay per admission	Not Covered	None
If you are pregnant	Office visits	\$750 Copay per admission	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: No Charge Outpatient services: \$20 Copay per visit	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Habilitation services	\$20 Copay per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$20 Copay per visit	Not Covered	For services with an ophthalmologist see "Specialist visit".
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Acupuncture • • • Cosmetic Surgery • Hearing Aids with limits(Adults) 	<ul style="list-style-type: none"> • • Long Term Care/Custodial Nursing Home Care • Non-emergency care when traveling outside the U.S. • Routine Dental Services 	<ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic Care • Hearing Aids with limits 	<ul style="list-style-type: none"> • Infertility Treatment • Private-Duty Nursing • Routine Eye Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copay] \$30
- Hospital (facility) [copay] \$750
- Other [coinsurance] 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copay] \$30
- Hospital (facility) [copay] \$750
- Other [coinsurance] 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,160

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copay] \$30
- Hospital (facility) [copay] \$750
- Other [coinsurance] 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò bèìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Fire Department Early Active HMO 220
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	Not applicable
5. Out-of-Pocket Maximum	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>
6. What is included in the In-	Coinsurance and copayments for Essential Health Benefits.

Network Out-of-Pocket Maximum?	
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

EXHIBIT A

Summaries of Benefits and Coverage

Denver Fire Department HDHP 1500 Active



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,500 Individual / \$3,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes, preventive services .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	\$3,000 Individual/ \$6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limits must be met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	Not Covered	None
	Specialist visit	20% Coinsurance	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Not subject to deductible .
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% Coinsurance Lab: 20% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$15 Copay; Mail Order: \$15 Copay	Not Covered	Subject to formulary guidelines; Non-preferred brand drugs: except those prescribed and authorized through the non-preferred drug process (subject to the brand copay). Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 60-day supply (retail prescription); 60 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$40 Copay; Mail Order: \$40 Copay	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	20% Coinsurance	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	None
	Physician/surgeon fees	20% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	Not Covered	None
	Inpatient services	20% Coinsurance	Not Covered	None
If you are pregnant	Office visits	20% Coinsurance	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: 20% Coinsurance	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Habilitation services	20% Coinsurance	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% Coinsurance.
	Hospice services	20% Coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	Not Covered	For services with an ophthalmologist see "Specialist visit".
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic Surgery • Hearing aids with limits (Adults) 	<ul style="list-style-type: none"> • Infertility treatment • Long Term Care/Custodial Nursing Home Care • Non-emergency care when traveling outside the U.S. • Routine Dental Services (Adult) 	<ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs 	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
<ul style="list-style-type: none"> • • 	<ul style="list-style-type: none"> • Hearing aids with limits 	<ul style="list-style-type: none"> • Private-Duty Nursing • Routine eye care 	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits

Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$600
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,460

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,590

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò bèìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **Kpoo 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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Fire Department HDHP 1500 Actives
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>AGGREGATE DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.</p>
5. Out-of-Pocket Maximum	<p>AGGREGATE OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.</p>

6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
 Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:


Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

EXHIBIT A


Summaries of Benefits and Coverage

Denver Fire Department PPO

*The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network portion is underwritten by KPIC, a subsidiary of KFHP.

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	PAR provider: \$300 Individual / \$900 Non-PAR provider: \$400 Individual / \$1,200 Family Does not apply to preventive care services	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family.
Are there services covered before you meet your deductible ?	Yes, preventive services , certain services with copays, prescription drugs and hospice.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	PAR provider: \$3,000 Individual / \$9,000 Non-PAR provider: \$6,000 Individual / \$18,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.Multiplan.com/Kaiser or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	Copay not subject to the deductible .
	Specialist visit	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	Copay not subject to the deductible .
	Preventive care/screening/immunization	No Charge	\$70 Copay per visit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. PAR provider: not subject to the deductible . Non-PAR: Copay not subject to the deductible .
If you have a test	Diagnostic test (x-ray, blood work)	During office: No Charge Freestanding clinic and outpatient department of a hospital: 20% Coinsurance	40% Coinsurance	PAR Provider: Diagnostic lab and x-ray services not subject to the deductible when provided during an office visit.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	20% penalty without pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$20 Copay; Mail Order: \$40 Copay	Not Covered except for diabetic supplies and oral chemotherapy drugs at 40% Coinsurance.	Subject to formulary guidelines; Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. PAR Provider: Federally mandated over the counter items are covered with a prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$30 Copay; Mail Order: \$60 Copay		
	Non-preferred brand drugs	Not Covered		
	Specialty drugs	20% Coinsurance up to \$250 per drug dispensed retail and mail order prescriptions		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	20% penalty without pre-certification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	20% penalty without pre-certification.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	Copay not subject to the deductible .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	20% penalty without pre-certification.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	20% penalty without pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	Group visit 50% of individual visit copay. PAR Provider: Copay not subject to the deductible .
	Inpatient services	20% Coinsurance	40% Coinsurance	20% penalty without pre-certification.
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) 20% penalty without pre-certification.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PAR Provider (You will pay more)	Non-PAR Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	PAR and Non-PAR provider: limited to 60 combined visits per calendar year. 20% penalty without pre-certification.
	Rehabilitation services	Inpatient services: 20% Coinsurance; Outpatient services: \$20 Copay per visit	Inpatient services: 40% Coinsurance; Outpatient services: 40% Coinsurance	Autism spectrum disorders are not subject to the outpatient visit limit. PAR and Non-PAR provider: combined outpatient visits limited to 20 visits per therapy per year. Combined inpatient: Multi-disciplinary facility limited to 60 days per condition per year. 20% penalty without pre-certification.
	Habilitation services	\$20 Copay per visit	40% Coinsurance	Autism spectrum disorders are not subject to the outpatient visit limit. PAR and Non-PAR provider: combined outpatient visits limited to 20 visits per therapy per year. 20% penalty without pre-certification.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Limited to 100 days per year.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Coverage is limited to items on our DME formulary. PAR and Non-PAR Provider: prosthetic arms and legs at 20% Coinsurance. 20% penalty without pre-certification. PAR Provider: Not subject to deductible
	Hospice services	No charge	40% Coinsurance	20% penalty without pre-certification.
	If your child needs dental or eye care	Children's eye exam	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	Not Covered
Children's glasses		Not Covered	Not Covered	None
Children's dental check-up		Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery•• Cosmetic Surgery• Hearing aids with limits (Adults)	<ul style="list-style-type: none">•• Long Term Care/Custodial Nursing Home Care• Non-emergency care when traveling outside the U.S.• Routine Dental Services	<ul style="list-style-type: none">•• Routine Foot Care• Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">••	<ul style="list-style-type: none">• Chiropractic care (PAR provider only)• Hearing aids with limits	<ul style="list-style-type: none">• Infertility treatment (PAR Provider and Non-PAR provider)• Private-Duty Nursing (PAR Provider only)• Routine eye care (PAR Provider Only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist](#) [copay] \$20
- Hospital (facility) [coinsurance] 20%
- Other [coinsurance] 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$40
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,700

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist](#) [copay] \$20
- Hospital (facility) [coinsurance] 20%
- Other [coinsurance] 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,260

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$300
- [Specialist](#) [copay] \$20
- Hospital (facility) [coinsurance] 20%
- Other [coinsurance] 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò bèìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Fire Department PPO Plan
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Preferred provider organization (PPO)
3. Areas of Colorado where plan is available.	Plan is available throughout Colorado

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.</p>
5. Out-of-Pocket Maximum	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered	No.

by this plan?	
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:


Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

EXHIBIT A


Summaries of Benefits and Coverage

Denver Fire Department POS

*The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network portion is underwritten by KPIC, a subsidiary of KFHP.

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-855-249-5005 or TTY 711. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/.com or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Plan Provider: \$0; PAR Provider: \$300 Individual / \$900 Family; Non-PAR Provider: \$400 Individual / \$1,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes, preventive services , certain services with copays, prescription drugs and hospice.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	Plan Provider: \$2,000 Individual / \$3,500 Family; PAR Provider: \$3,000 Individual / \$9,000 Family; Non-PAR Provider: \$6,000 Individual / \$18,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-855-249-5005 or TTY 711 for a list of plan providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copay per visit	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	Copay not subject to the deductible .
	Specialist visit	\$30 Copay per visit	\$35 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	Copay not subject to the deductible .
	Preventive care/screening/immunization	No Charge	No Charge	\$70 Copay per visit	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Plan and PAR provider: not subject to the deductible . Non-PAR: Copay not subject to the deductible .
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge Lab: No Charge	During office: No Charge Freestanding clinic and outpatient department of a hospital: 20% Coinsurance	40% Coinsurance	Plan Provider: Diagnostic lab services: not subject to the deductible except when provided in the outpatient department of a hospital; PAR Provider: Diagnostic lab and x-ray services not subject to the deductible when provided during an office visit.
	Imaging (CT/PET scans, MRIs)	\$100 Copay per test	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org	Generic drugs	Retail: \$15 Copay; Mail Order: \$30 Copay	Retail: \$25 Copay; Mail Order: \$50 Copay	Retail: 50% Coinsurance; Mail Order: Not Covered	Subject to formulary guidelines; Non-preferred brand drugs: except those prescribed and authorized through the non-preferred drug process (subject to the brand copay). Plan provider: Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. PAR Provider: Federally mandated over the counter items are covered with a prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: \$30 Copay; Mail Order: \$60 Copay	Retail: \$35 Copay; Mail Order: \$70 Copay	Retail: 50% Coinsurance; Mail Order: Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	Retail: 50% Coinsurance; Mail Order: Not Covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	20% Coinsurance up to \$250 per drug dispensed retail and mail order prescriptions	Retail: 50% Coinsurance up to \$250 per drug dispensed retail; Mail Order: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 Copay per visit	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
	Physician/surgeon fees	\$300 Copay per visit	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you need immediate medical attention	Emergency room care	\$100 Copay per visit	\$100 Copay per visit	\$100 Copay per visit	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance up to \$500	20% coinsurance up to \$500	20% coinsurance up to \$500	Not subject to the deductible .
	Urgent care	\$50 Copay per visit	\$50 Copay per visit	\$50 Copay per visit	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to the deductible .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 Copay per admission	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR provider (You will pay the most)	
	Physician/surgeon fees	\$750 Copay per admission	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay per visit	\$20 Copay per visit; 20% Coinsurance for covered services received during a visit.	40% Coinsurance	Group visit 50% of individual visit copay. Copay not subject to the deductible .
	Inpatient services	\$750 Copay per admission	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
If you are pregnant	Office visits	\$750 Copay per admission	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification.
	Childbirth/delivery professional services				
	Childbirth/delivery facility services				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	20% Coinsurance	40% Coinsurance	Plan Provider: limited to less than 8 hours per day and 28 hours per week. PAR and Non-PAR Provider: limited to 60 combined visits per calendar year. Non-Plan Provider: 20% penalty without pre-certification.
	Rehabilitation services	Inpatient services: No Charge; Outpatient services: \$20 Copay per visit	Inpatient services: Not Covered; Outpatient services: 20% Coinsurance	Inpatient services: Not Covered; Outpatient services: 40% Coinsurance	Autism spectrum disorders are not subject to the outpatient visit limit. Plan provider: outpatient visits limited to 20 visits per therapy per year; inpatient in a multi-disciplinary facility limited to 60 days per condition per year. PAR and Non-PAR Provider: combined outpatient visits limited to 20 visits per therapy per year. Non-Plan Provider: 20% penalty without pre-certification. Copay not subject to the deductible .
	Habilitation services	\$20 Copay per visit	20% Coinsurance	40% Coinsurance	Autism spectrum disorders are not subject to the outpatient visit limit. Plan Provider: outpatient visits limited to 20 visits per therapy per year; PAR and Non-PAR Provider: combined outpatient visits limited to 20 visits per therapy per year. Non-Plan Provider: 20% penalty without pre-certification. Copay not subject to the deductible .
	Skilled nursing care	No Charge	Services are covered at the Plan Provider level	Services are covered at the Plan Provider level	Limited to 100 days per year. Non-Plan Provider: 20% penalty without pre-certification.
	Durable medical equipment	20% Coinsurance	Not covered except for the replacement of an arm or leg (20% Coinsurance)	Not covered except for the replacement of an arm or leg (20% Coinsurance)	Coverage is limited to items on our DME formulary. Plan Provider: prosthetic arms and legs at 20% Coinsurance. PAR and Non-PAR Provider: prosthetic arms and legs at 20% Coinsurance. Non-Plan Provider: 20% penalty without pre-certification.
	Hospice services	No Charge	20% Coinsurance	40% Coinsurance	Non-Plan Provider: 20% penalty without pre-certification. Plan Provider: not subject to the deductible .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	PAR Provider (You will pay more)	Non-PAR Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$20 Copay per visit	Not Covered	Not Covered	For services with an ophthalmologist see "Specialist visit". Copay not subject to the deductible .
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic Surgery Hearing aids with limits (Adults) 	<ul style="list-style-type: none"> Long Term Care/Custodial Nursing Home Care Non-emergency care when traveling outside the U.S. Routine Dental Services 	<ul style="list-style-type: none"> Routine Foot Care Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Bariatric surgery (Plan Provider only) 	<ul style="list-style-type: none"> Chiropractic care (Plan Provider & PAR Provider only) Hearing aids with limits 	<ul style="list-style-type: none"> Infertility treatment (Plan Provider only) Private-Duty Nursing (Plan Provider only) Routine eye care (Plan Provider Only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copay] \$30
- Hospital (facility) [copay] \$750
- Other [coinsurance] 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copay] \$30
- Hospital (facility) [copay] \$750
- Other [copay] 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,160

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copay] \$30
- Hospital (facility) [copay] \$750
- Other [coinsurance] 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 ተዘጋጅተዋል። 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**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudù kà kò dò po-poò bèìn 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) NRUBAMA: O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **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'déé', t'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क 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).

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado and Kaiser Permanente Insurance Company
NAME OF PLAN	Denver Fire Department Active POS
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Point of Service Plan (POS)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties as determined by zip code and employer service area selection:</p> <ol style="list-style-type: none"> 1. For Denver/Boulder service area: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld; 2. For Southern Colorado: Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller; 3. For Southern Colorado KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller; 4. For Northern Colorado: Adams, Larimer, Morgan, and Weld; 5. For Mountain Colorado: Eagle, Garfield, Grand, Routt and Summit.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	Not Applicable
5. Out-of-Pocket Maximum	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>
6. What is included in the In-Network Out-of-Pocket Maximum?	Coinsurance and copayments for Essential Health Benefits.

7. Is pediatric dental covered by this plan?	No.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
8. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
9. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874
 Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

EXHIBIT A

**Underwriting Assumptions
and Requirements**


Rate Assumptions and Requirements
Region: Colorado
Group Name: City and County of Denver 2018 Renewal
Contract Period: 01/01/2018 – 12/31/2018
Group Numbers: 75
**Subgroups: 001,002,003,007,008,011,013,
014,015,029,033,034,035,039**
KP Offered: Alongside other carrier(s)
Quotes Included

 CCD 2018 DHMO – 17216340
 CCD 2018 HDHP – 17216343

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. Group-specific requirements:

None

2. Rating Assumptions:

Rates assume a 12-month policy period of 12/1/2017 through 11/30/2018 unless otherwise specified above.

The rates and benefits in this proposal include the Federal Health Care Reform requirements. If the insured employer makes changes in excess to those allowed under the interim final guidance in the Patient Protection and Affordable Care Act (PPACA), the plan would not be grandfathered and would have all applicable PPACA mandates applied. For confirmation of the status of your plan, please contact your Kaiser Permanente account manager. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.

KP reserves the right to re-rate if actual enrollment results in a +/- 10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:

- a. A change in the demographic factor.
- b. A change in the average family size or subscriber distribution.
- c. A change in the number of subscribers enrolled in KP.
- d. A change in the number of plans offered alongside KP.
- e. A change in the benefit design of a plan offered alongside KP.
- f. A change in the employer contribution formula.
- g. Groups must abide by the Break-in and Break-away Policy.

KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. Participation and contribution requirements:

- a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
- b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. Quote assumes KP is offered alongside another health care plan

KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:

- a. KP is offered to all eligible employees.
- b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.

 Rate Assumptions and Requirements

Region: Colorado

Group Name: City and County of Denver 2018 Renewal

Contract Period: 01/01/2018 - 12/31/2018

Group Numbers: 75

Subgroups: 001,002,003,007,008,011,013,
014,015,029,033,034,035,039

KP Offered: Alongside other carrier(s)

- c. The employer's contribution formula does not put KP in a disadvantaged position. This quote assumes that all benefit plans offered to group subscribers provide similar benefits and levels of coverage. If not, the employer's contribution strategy must account for benefit differences among plans offered to subscribers. For example, if KP provides coverage in excess of the minimum essential level of coverage required by law, and another plan does not, the employer will ensure that the member contribution for KP's plan does not exceed the dollar amount for the other plan.
 - d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
 - e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
 - f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
 - g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.
 - h. No other plan is allowed preferential treatment that adversely affects KP.
 - i. KP prefers that the number of employee subscribers enrolled in KP be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
 - j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
 - k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).
5. **Product-specific participation requirements:**
- Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:
- a. Please refer to the group's contract for full definitions of Primary Medicare and Secondary Medicare.
 - b. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. In some regions members with only Part B may also enroll but their rates will be subject to a surcharge.
 - c. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
 - d. Enrollment in Medicare Senior Advantage (KPSA), Medicare Plus and Medicare Cost is contingent upon receipt of an accurately completed enrollment form.
 - e. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
 - f. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.
- Additional Out-of-Area Product Requirements:
- a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.
6. **Proposal requires eligibility for KP plan based on the following:**
- a. Employer - the employer cannot be considered a small group according to state law.
 - b. Actives:
 - The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
 - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and works the minimum number of hours mandated by federal and/or state law to be considered an "eligible employee." Any agreement to change the minimum hours required must be in writing. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
 - The employee must live only in the service area specific to the product they enroll in.
 - 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.
 - c. New enrollees:

The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.

 Rate Assumptions and Requirements

Region: Colorado

Group Name: City and County of Denver 2018 Renewal

Contract Period: 01/01/2018 - 12/31/2018

Group Numbers: 75

Subgroups: 001,002,003,007,008,011,013,
014,015,029,033,034,035,039

KP Offered: Alongside other carrier(s)

d. COBRA

- It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
- It is the employer's responsibility to comply with appropriate COBRA statutes.
- KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.

e. Retirees

- Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
- Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
- Medicare eligible retirees cannot enroll in the active plan.
- Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.

f. Dependents

- If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. Compliance:

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

8. Broker Payment:

Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

 Rate Assumptions and Requirements

Region: Colorado

Group Name: Denver Police 2018 Renewal

Contract Period: 1/01/2018 - 12/31/2018

Group Numbers: 68

Subgroups: 001,002,011,012,014,030,032,
035,038,039,041,050,051,060

KP Offered: Alongside other carrier(s)

Quotes Included

Denver Police 2018 DHMO - Current - 17227767

Denver Police 2018 HDHP - Current - 17227769

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the participation and contribution requirements described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. Group-specific requirements:

None

2. Rating Assumptions:

Rates assume a 12-month policy period of 12/1/2017 through 11/30/2018 unless otherwise specified above.

The rates and benefits in this proposal include the Federal Health Care Reform requirements. If the insured employer makes changes in excess to those allowed under the Interim final guidance in the Patient Protection and Affordable Care Act (PPACA), the plan would not be grandfathered and would have all applicable PPACA mandates applied. For confirmation of the status of your plan, please contact your Kaiser Permanente account manager. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.

KP reserves the right to re-rate if actual enrollment results in a +/-10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:

- a. A change in the demographic factor.
- b. A change in the average family size or subscriber distribution.
- c. A change in the number of subscribers enrolled in KP.
- d. A change in the number of plans offered alongside KP.
- e. A change in the benefit design of a plan offered alongside KP.
- f. A change in the employer contribution formula.
- g. Groups must abide by the Break-In and Break-away Policy.

KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. Participation and contribution requirements:

- a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
- b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. Quote assumes KP is offered alongside another health care plan

KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:

- a. KP is offered to all eligible employees.
- b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.


Rate Assumptions and Requirements
Region: Colorado

Group Name: Denver Police 2018 Renewal

Contract Period: 1/01/2018 – 12/31/2018

Group Numbers: 68

Subgroups: 001,002,011,012,014,030,032,
035,038,039,041,050,051,060

KP Offered: Alongside other carrier(s)

- c. The employer's contribution formula does not put KP in a disadvantaged position. This quote assumes that all benefit plans offered to group subscribers provide similar benefits and levels of coverage. If not, the employer's contribution strategy must account for benefit differences among plans offered to subscribers. For example, if KP provides coverage in excess of the minimum essential level of coverage required by law, and another plan does not, the employer will ensure that the member contribution for KP's plan does not exceed the dollar amount for the other plan.
- d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
- e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
- f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
- g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.
- h. No other plan is allowed preferential treatment that adversely affects KP.
- i. KP prefers that the number of employee subscribers enrolled in KP be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
- j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
- k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. Product-specific participation requirements:
Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

- a. Please refer to the group's contract for full definitions of Primary Medicare and Secondary Medicare.
- b. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. In some regions members with only Part B may also enroll but their rates will be subject to a surcharge.
- c. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
- d. Enrollment in Medicare Senior Advantage (KPSA), Medicare Plus and Medicare Cost is contingent upon receipt of an accurately completed enrollment form.
- e. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
- f. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

- a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. Proposal requires eligibility for KP plan based on the following:

- a. Employer – the employer cannot be considered a small group according to state law.
- b. Actives:
 - The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
 - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and works the minimum number of hours mandated by federal and/or state law to be considered an "eligible employee." Any agreement to change the minimum hours required must be in writing. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
 - The employee must live only in the service area specific to the product they enroll in.
 - 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.
- c. New enrollees:

The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.

 Rate Assumptions and Requirements

Group Name: Denver Police 2018 Renewal

Region: Colorado

Contract Period: 1/01/2018 - 12/31/2018

Group Numbers: 68

Subgroups: 001,002,011,012,014,030,032,
035,038,039,041,050,051,060

KP Offered: Alongside other carrier(s)

d. COBRA

- It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
- It is the employer's responsibility to comply with appropriate COBRA statutes.
- KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.

e. Retirees

- Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
- Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
- Medicare eligible retirees cannot enroll in the active plan.
- Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.

f. Dependents

- If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. Compliance:

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

8. Broker Payment:

Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

EXHIBIT A
PERFORMANCE GUARANTEES

Kaiser Permanente Colorado
2018 Performance Guarantees Agreement
City and County of Denver

Guaranteed Performance

We are pleased to offer a performance guarantee backed by a percentage of your annual non-Medicare premium if you have an average of 500 or more non-Medicare members in Kaiser Permanente Colorado in 2018. (In 2019, we will conduct a review of your 2018 monthly membership to determine the annual average.)

Changes in Measures

Some of our performance measures use definitions determined by national organizations such as the National Committee for Quality Assurance (NCQA.) If the definition for such a measure changes after these guarantees have been implemented we can no longer guarantee the measure. This includes any changes by NCQA in reporting rules or decisions by NCQA regarding publication of the Quality Compass. We do not accept conversions or substitutions of HEDIS measures. Should any guaranteed HEDIS measure be rotated for calendar year 2018 it will be ignored for purposes of performance evaluation and penalty calculation.

If we are unable to provide any of the information guaranteed in this agreement due to federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties.

Setting Penalty Thresholds

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.

Reporting Frequency and Guarantee Duration

Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year and a semi-annual performance report for the current year. Performance guarantees require annual renewal and must be requested each year by the purchaser.

Penalty Payments

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 your total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check.

Forfeiture on sample-based measures is contingent on statistically meaningful variations from penalty thresholds. A standard statistical test is used to determine whether results are above or below the applicable state/regional or national average. If the test shows that the differences in the results are too large to be explained by random chance, but are true differences at least 95% of the time, the results are considered statistically different from the penalty threshold.

Issues leading to failure on measures of satisfaction with account management are defined as those related to the administration of the plan that are under direct control of the account management team (e.g. account management adequately answers customer questions, keeps customer informed of new developments, strives to resolve administrative problems.) Issues related to other health plan areas (e.g. pricing, member call centers, 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 purchaser 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 Colorado
2018 Performance Guarantees Agreement
City and County of Denver**

Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except for measures where the penalty threshold is shown with a decimal point (e.g., ≤3.0%)

2018 Performance Measures		Penalty Threshold	Penalty (% of Premium)
Implementation, Administration and Account Management			
1.	Clean Eligibility files initial upload completed within 2 business of receipt when file is received prior to 2:15 pm MST	93%	0.10%
2.	Premium/Eligibility reconciliation within 30 calendar days (% of purchasers) ¹	85%	0.10%
3.	ID card processing within 10 business days	93%	0.10%
4.	Contract/Booklet Updates	Provided within 60 days	0.10%
5.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.10%
Member Services			
6.	Member Services calls answered within 30 seconds	80%	0.10%
7.	Telephone call abandonment rate	≤ 3.0%	0.10%
8.	First contact resolution	85%	0.10%
Member Satisfaction and Access			
9.	Overall member satisfaction with health plan (CAHPS 4.0 #42; % 8-10)	≥ CO HMO Avg.*	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)	90%	0.10%
Quality (HEDIS Effectiveness of Care)			
13.	Diabetes – Controlling High Blood Pressure	≥ Natl. HMO Avg.*	0.10%
14.	Colorectal Cancer Screening Rate	≥ Natl. HMO Avg.*	0.10%
15.	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. HMO Avg.*	0.10%
16.	Use of Appropriate Medications for Asthma	≥ Natl. HMO Avg.*	0.10%
17.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. HMO Avg.*	0.10%
18.	Cervical Cancer Screening Rate	≥ Natl. HMO Avg.*	0.10%
19.	Mammography Screening Rate	≥ Natl. HMO Avg.*	0.10%
Reporting			
20.	Timely performance reporting	Performance report listed are due 60 days after end of the quarter	0.10%
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.

* Penalties are contingent on statistically meaningful differences from targets

Kaiser Permanente Colorado
2018 Performance Guarantees Agreement
City and County of Denver

ACCOUNT TEAM ASSESSMENT FORM

	Strongly Agree		Neutral		Strongly Disagree
	5	4	3	2	1
1. The Account Management Team* demonstrates a clear understanding of the group's business needs and plan design(s).					
2. The Account Manager and Associate Account Manager are knowledgeable about the products and services they provide.					
3. Account Management Team communicates clearly both written and verbally:					
<ul style="list-style-type: none"> • Account Manager 					
<ul style="list-style-type: none"> • Associate Account Manager 					
<ul style="list-style-type: none"> • Client Service Unit 					
<ul style="list-style-type: none"> • Billing 					
4. Responses to data and statistical reporting requests are prompt and accurate.					
<ul style="list-style-type: none"> • Account Manager 					
<ul style="list-style-type: none"> • Associate Account Manager 					
<ul style="list-style-type: none"> • Client Service Unit 					
<ul style="list-style-type: none"> • Billing 					
5. Notifies group promptly when issues arise and work proactively to prevent problems.					
6. Follow-up to ensure problems are resolved quickly and to group's level of satisfaction.					
<ul style="list-style-type: none"> • Account Manager 					
<ul style="list-style-type: none"> • Associate Account Manager 					
7. Sales team members are responsive and take ownership of issues and requests.					
<ul style="list-style-type: none"> • Account Manager 					
<ul style="list-style-type: none"> • Associate Account Manager 					
8. Responses to contract issues and questions are prompt and accurate.					

**Kaiser Permanente Colorado
2018 Performance Guarantees Agreement
City and County of Denver**

	Strongly Agree		Neutral		Strongly Disagree
	5	4	3	2	1
9. Responses to administrative, claims payment and eligibility questions are prompt and accurate by Account Manager and/or Associate Account Manager.					
10. Responses to accounting and billing questions are prompt and accurate.					
11. Responses to network questions and advisement of network changes are prompt and accurate.					
12. Account Manager's Team members are professional at all times.					
<ul style="list-style-type: none"> • Account Manager • Associate Manager 					
14. Responses to renewal and rating questions are prompt and accurate.					
Total Score					
Percent of Maximum Possible Score					
Minimum Percentage (75%)					

*Account Management consists of: Account Manager, Associate Account Manager, Sales Support Associates, Underwriting, Representative of Client Services Unit, Management / Directors / Executive Directors involved in day to day operations and management of this group.

Assessment to be completed annually by group representative and reviewed with Kaiser Permanente account management team. For anything below or at a "neutral" score please provide documentation along with expectations.

Assessment is to be initiated by Kaiser Permanente to the client in a consistent and timely manner.

Kaiser Permanente Colorado
2018 Performance Guarantees Agreement
Denver Police Department

Guaranteed Performance

We are pleased to offer a performance guarantee backed by a percentage of your annual non-Medicare premium if you have an average of 500 or more non-Medicare members in Kaiser Permanente Colorado in 2018. (In 2019, we will conduct a review of your 2018 monthly membership to determine the annual average.)

Changes in Measures

Some of our performance measures use definitions determined by national organizations such as the National Committee for Quality Assurance (NCQA.) If the definition for such a measure changes after these guarantees have been implemented we can no longer guarantee the measure. This includes any changes by NCQA in reporting rules or decisions by NCQA regarding publication of the Quality Compass. We do not accept conversions or substitutions of HEDIS measures. Should any guaranteed HEDIS measure be rotated for calendar year 2016 it will be ignored for purposes of performance evaluation and penalty calculation.

If we are unable to provide any of the information guaranteed in this agreement due to federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties.

Setting Penalty Thresholds

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.

Reporting Frequency and Guarantee Duration

Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year and a semi-annual performance report for the current year. Performance guarantees require annual renewal and must be requested each year by the purchaser.

Penalty Payments

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 your total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check.

Forfeiture on sample-based measures is contingent on statistically meaningful variations from penalty thresholds. A standard statistical test is used to determine whether results are above or below the applicable state/regional or national average. If the test shows that the differences in the results are too large to be explained by random chance, but are true differences at least 95% of the time, the results are considered statistically different from the penalty threshold.

Issues leading to failure on measures of satisfaction with account management are defined as those related to the administration of the plan that are under direct control of the account management team (e.g. account management adequately answers customer questions, keeps customer informed of new developments, strives to resolve administrative problems.) Issues related to other health plan areas (e.g. pricing, member call centers, 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 purchaser 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 Colorado
2018 Performance Guarantees Agreement
Denver Police Department**

Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except for measures where the penalty threshold is shown with a decimal point (e.g., ≤3.0%)

2018 Performance Measures		Penalty Threshold	Penalty (% of Premium)
<i>Implementation, Administration and Account Management</i>			
1.	Eligibility information accessible to medical groups within eight business days	95%	0.11%
2.	Premium/Eligibility reconciliation within 30 calendar days (% of purchasers) ¹	85%	0.11%
3.	ID card processing within 10 business days	95%	0.11%
4.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.12%
<i>Member Services</i>			
5.	Member Services calls answered within 30 seconds	80%	0.10%
6.	Telephone call abandonment rate	≤ 3.0%	0.10%
<i>Member Satisfaction and Access</i>			
7.	Overall member satisfaction with health plan (CAHPS 4.0 #42; % 8-10)	≥ CO HMO Avg.*	0.12%
8.	Member satisfaction with customer service (CAHPS 4.0 composite #s 35, 36; (% 'usually or always')	≥ CO HMO Avg.*	0.12%
9.	Member rating of personal doctor (CAHPS 4.0 #21; 8-10)	≥ CO HMO Avg.*	0.12%
10.	Kp.org web site availability (for non-secure sections, and excluding scheduled maintenance)	98.5%	0.12%
<i>Quality (HEDIS Effectiveness of Care)</i>			
11.	Diabetes – Controlling High Blood Pressure	≥ Natl. HMO Avg.*	0.12%
12.	Colorectal Cancer Screening Rate	≥ Natl. HMO Avg.*	0.10%
13.	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. HMO Avg.*	0.10%
14.	Use of Appropriate Medications for Asthma	≥ Natl. HMO Avg.*	0.11%
15.	Persistence of Beta Blocker Treatment after Heart Attack	≥ Natl. HMO Avg.*	0.11%
16.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. HMO Avg.*	0.11%
17.	Cervical Cancer Screening Rate	≥ Natl. HMO Avg.*	0.11%
18.	Mammography Screening Rate	≥ Natl. HMO Avg.*	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.

* Penalties are contingent on statistically meaningful differences from targets

Kaiser Permanente Colorado 2018 Performance Guarantees Agreement Denver Fire Department

Guaranteed Performance

We are pleased to offer a performance guarantee backed by a percentage of your annual non-Medicare premium if you have an average of 500 or more non-Medicare members in Kaiser Permanente Colorado in 2018. (In 2019, we will conduct a review of your 2018 monthly membership to determine the annual average.)

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. Some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA.) If the definition of an NCQA measure changes, if an NCQA HEDIS measure is rotated, or if NCQA changes its 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, 2018, 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 Colorado
2018 Performance Guarantees Agreement
Denver Fire Department**

Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except for measures where the penalty threshold is shown with a decimal point (e.g., ≤3.0%)

2018 Performance Measures		Penalty Threshold	Penalty (% of Premium)
<i>Implementation, Administration and Account Management</i>			
1.	Eligibility information accessible to medical groups within eight business days	95%	0.11%
2.	Premium/Eligibility reconciliation within 30 calendar days (% of purchasers) ¹	85%	0.11%
3.	ID card processing within 10 business days	95%	0.11%
4.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.12%
<i>Member Services</i>			
5.	Member Services calls answered within 30 seconds	80%	0.10%
6.	Telephone call abandonment rate	≤ 3.0%	0.10%
<i>Member Satisfaction and Access</i>			
7.	Member satisfaction with health plan (CAHPS #42; % 8-10)	≥ CO HMO Avg.*	0.12%
8.	Member satisfaction with customer service composite (CAHPS #s 35, 36; % 'usually or always')	≥ CO HMO Avg.*	0.12%
9.	Member rating of personal doctor (CAHPS #23; 8-10)	≥ CO HMO Avg.*	0.12%
10.	Kp.org web site availability (for non-secure sections, and excluding scheduled maintenance)	98.5%	0.12%
<i>Quality (HEDIS Effectiveness of Care)</i>			
11.	Diabetes – Controlling High Blood Pressure	≥ Natl. HMO Avg.*	0.12%
12.	Colorectal Cancer Screening Rate	≥ Natl. HMO Avg.*	0.10%
13.	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. HMO Avg.*	0.10%
14.	Asthma Medication Ratio	≥ Natl. HMO Avg.*	0.11%
15.	Persistence of Beta Blocker Treatment after Heart Attack	≥ Natl. HMO Avg.*	0.11%
16.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. HMO Avg.*	0.11%
17.	Controlling High Blood Pressure	≥ Natl. HMO Avg.*	0.11%
18.	Cervical Cancer Rate	≥ Natl. HMO Avg.*	0.11%
<i>Total Percent at Risk</i>			2.00 %

¹ The 30-day calendar starts the day Kaiser Permanente has received both the premium and the premium report.

* Penalties are contingent on statistically meaningful differences from targets

EXHIBIT A
KAISER FOUNDATION HEALTH PLAN
OF COLORADO

Evidence of Coverage – DHMO 500

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 “Kaiser Permanente,” “Health 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 2018 contract year.

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 the number provided below.

Colorado	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 with the Kaiser Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, telephone number: 1-800-632-9700. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. 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

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or this notice requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter. Colorado 1-800-632-9700 (TTY 711)

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሲር ፐርማኒንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የሰልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውሎ ከአስተርጓሚ ጋር ይነጋገሩ።
Colorado 1-800-632-9700 (TTY 711)

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو يتطلب هذا الإشعار منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.
Colorado 1-800-632-9700 (TTY 711)

Bàsòò Wùdù (Bassa): M bédé dyí-bèdèin-dèò bé m ké gbo-kpá-kpá dyé dé m bídí-wùdùün bó pídyi. ɔ jù ké m dyi dyi-dieñ-dè bé bédé bá ni dè-mó-dìfèdèò dyí, mɔɔ bá ni kùün kpɔ jè dyí dyiìn dé Kaiser Permanente mú, mɔɔ ɔ jù ké bɔi-po-po nià ke dyi níin m me nyùin dè dò wé jéé dò kɔe ni, nií, dá nòbà bé wa tòà bó ni gbèè vèné mɔɔ ni gbèè dyùò jèe bé m ké wuɔu-zìin-nyò dò gbo wùdù.
Colorado 1-800-632-9700 (TTY 711)

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。
Colorado 1-800-632-9700 (TTY 711)

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.
Colorado 1-800-632-9700 (TTY 711)

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.
Colorado 1-800-632-9700 (TTY 711)

Igbo (Igbo): ! nwere ikike inweta enyemaka n’asụsụ gi na akwụghị ugwo ọ bụla. Ọ bụrụ na i nwere ajụjụ gbasara akwụkwọ anamachọihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ na ọkwa a chọrọ ka i mee ihe tupu otu ụbọchị, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi iji kwukọrịta okwu n’etiti onye ọkọwa okwu.
Colorado 1-800-632-9700 (TTY 711)

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳と、お話しください。
Colorado 1-800-632-9700 (TTY 711)

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente 를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 일정 날짜까지 조취를 취해야 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.
Colorado 1-800-632-9700 (TTY 711)

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Naabeehó (Navajo): T'áá ni nizaad bee níká i' doolwoł doo bik'é asíníłáágóó éi bee náhaz'á. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinilaa, éi bína'ídíłkid doogo, éi doodago díí naaltsoos haa'ída yoolkáalgo hait'áoda í' dííłíł níłníigo éi nitsaa hahoodzojí éi doodago t'áá aadi nahós'a' di ata' dahalne'ígíí bich'í' hólne'go bee bił ahíł hodíílnih.

Colorado 1-800-632-9700 (TTY 711)

नेपाली (Nepali): तपाईंसंग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नुपरेमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Colorado 1-800-632-9700 (TTY 711)

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan beeksisi Kun guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu kan gaafatu yoo ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bibiluudhaan turjumaana haasofisiisi.

Colorado 1-800-632-9700 (TTY 711)

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

Colorado 1-800-632-9700 (TTY 711)

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо данное уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Colorado 1-800-632-9700 (TTY 711)

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o este aviso requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se le proporcionó para su estado o región para hablar con un intérprete.

Colorado 1-800-632-9700 (TTY 711)

Tagalog (Tagalog): Mayroon kang karapatan na kumuha ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o ang abisong ito ay nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap usap sa tagapagsalin.

Colorado 1-800-632-9700 (TTY 711)

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc thông báo này yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Colorado 1-800-632-9700 (TTY 711)

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti rí irànlọ́wọ́ gbà nípa èdè ẹ̀ láìsan owó. Bí o bá ní ìbèèrè nípa ìṣàfilọ̀lẹ̀ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ifitọ̀nilétí yìí fẹ́ kí gbé ìgbésẹ̀ kan ní ojú kan patọ̀, pé nọmbà tí a pèsè fún ipínlẹ̀ tàbí agbègbè ẹ̀ láti bá òngbifọ̀ kan sọrọ̀.

Colorado 1-800-632-9700 (TTY 711)

CITY AND COUNTY OF DENVER
EVIDENCE OF COVERAGE AMENDMENT - 2018

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, step-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 both: career service employees as defined in section 9.1.1(e) of the charter, and appointed charter officers as defined in section 9.2.1(B) 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, 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.

(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. 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. A Plan Physician ***must*** determine that the Service is ***Medically Necessary*** to prevent, diagnose, or treat your medical condition. A Service is Medically Necessary ***only*** if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; ***and***
 - b. The Service ***must be*** provided, prescribed, authorized, or directed by a Plan Physician; ***and***
 - c. The Service ***must be a covered*** Service described in this EOC.
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.
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. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. 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.
7. 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.
8. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

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 over usual, reasonable and customary 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 Out-of-Pocket Maximum (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 always 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”, “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”, “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 Out-of-Pocket Maximum (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 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 over usual, reasonable and customary 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 send you 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**.

Benefits for CITY AND COUNTY OF DENVER

75 - 050

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

\$1,500/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

\$3,000/Individual per Accumulation Period

\$6,000/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 <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$30 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Specialty care visits <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$50 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Consultations with clinical pharmacists <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$30 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Allergy evaluation and testing <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	\$50 Copayment each visit
Allergy injections <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$30 Copayment each visit Covered Services including allergy serum received during a visit: 20% Coinsurance
Gynecology care visits <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$50 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Routine prenatal and postpartum visits <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Office-administered drugs <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance (prostate cancer drugs only) All other office-administered drugs @ No Charge
<ul style="list-style-type: none"> • Travel immunizations 	No Charge
Telemedicine	
<ul style="list-style-type: none"> • Email <ul style="list-style-type: none"> o Primary care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> o Specialty care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> • Online <ul style="list-style-type: none"> o Primary care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> o Specialty care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> • Telephone <ul style="list-style-type: none"> o Primary care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> o Specialty care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	No Charge No Charge No Charge No Charge No Charge No Charge
Telehealth	
<ul style="list-style-type: none"> • Video visits <ul style="list-style-type: none"> o Primary care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> o Specialty care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	\$30 Copayment each visit \$50 Copayment each visit
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 Medical Office <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	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 <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Outpatient hospital Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Hospital Inpatient Care	You Pay
<i>(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services)</i> <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Inpatient professional Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Alternative Medicine	You Pay
Chiropractic care	
<ul style="list-style-type: none"> Evaluation and/or manipulation <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> Laboratory Services or x-rays required for chiropractic care <i>(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)</i> 	\$30 Copayment each visit Up to 20 visits per Accumulation Period See Additional Provisions See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance
Acupuncture Services <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Ambulance Services	You Pay
<i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance Up to \$500 per trip
Bariatric Surgery	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	50% Coinsurance Includes inpatient and outpatient covered Services
Chemical Dependency Services	You Pay
Inpatient medical detoxification <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Inpatient professional Services for medical detoxification <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Outpatient individual therapy <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$30 Copayment each visit \$30 Copayment per partial hospitalization day Covered Services received during a visit: 20% Coinsurance
Outpatient group therapy <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: 50% of individual therapy Copayment Covered Services received during a visit: 20% Coinsurance
Residential rehabilitation <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance per inpatient admission

Dental Services following Accidental Injury	You Pay
<i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Dialysis Care	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance See Additional Provisions
<ul style="list-style-type: none"> Breast pumps <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	No Charge
Prosthetic devices	
<ul style="list-style-type: none"> Internally implanted prosthetic devices <i>(See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information)</i> 	See "Outpatient Hospital and Surgical Services" and "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance
<ul style="list-style-type: none"> Prosthetic arm or leg <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance
<ul style="list-style-type: none"> All other prosthetic devices <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance
Orthotic devices <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Oxygen <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	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.	
Plan and non-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	<p>\$200 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.</p> <p>If X-ray special procedures are excluded, see "X-ray, Laboratory and X-ray Special Procedures" for applicable Copayment or Coinsurance.</p>

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)

\$75 Copayment each visit

Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.

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)

\$75 Copayment each visit

Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.

Covered Services received during a visit: 20% Coinsurance

Covered only if all the following requirements are met:

- The care is required to prevent serious decline of health
 - The need for care results from an unforeseen illness or injury when temporarily away from our Service Area
 - The care cannot be delayed until you return to our Service Area
-

Family Planning 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 "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
<p>Hearing exams and tests to determine the need for hearing correction when performed by an audiologist</p> <p><i>Exam: (Copayment not subject to medical Deductible Coinsurance subject to medical Deductible; Copayment applies to Out-of-Pocket Maximum Coinsurance applies to Out-of-Pocket maximum) Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i></p>	<p>Exam: \$30 Copayment each visit Covered Services received during a visit: 20% Coinsurance</p>
<p>Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist</p> <p><i>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)</i></p>	<p>Exam: \$50 Copayment each visit Covered Services received during a visit: 20% Coinsurance</p>
<p>Hearing aids for Members up to age 18</p> <p><i>(Copayment not subject to medical Deductible Coinsurance subject to medical Deductible; Copayment applies to Out-of-Pocket Maximum Coinsurance applies to Out-of-Pocket maximum)</i></p>	<p>20% Coinsurance</p>
<ul style="list-style-type: none"> Fitting and Recheck visits <p><i>(Copayment not subject to medical Deductible Coinsurance subject to medical Deductible; Copayment applies to Out-of-Pocket Maximum Coinsurance applies to Out-of-Pocket maximum)</i></p>	<p>20% Coinsurance</p>
<p>Hearing aids for Members age 18 and over</p> <p><i>(Copayment not subject to medical Deductible Coinsurance subject to medical Deductible; Copayment applies to Out-of-Pocket Maximum Coinsurance applies to Out-of-Pocket maximum)</i></p>	<p>Not Covered</p>
<ul style="list-style-type: none"> Fitting and Recheck visits <p><i>(Copayment not subject to medical Deductible Coinsurance subject to medical Deductible; Copayment applies to Out-of-Pocket Maximum Coinsurance applies to Out-of-Pocket maximum)</i></p>	<p>Not Covered</p>
Home Health Care	You Pay
<p>Home health Services provided in your home and prescribed by a Plan Physician</p> <p><i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i></p>	<p>20% Coinsurance</p>
Hospice Care	You Pay
<p>Special Services program for hospice-eligible Members who have not yet elected hospice care</p> <p><i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i></p>	<p>No Charge</p>
<p>Hospice care for terminally ill patients</p> <p><i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i></p>	<p>No Charge</p>
Infertility Services	You Pay
<p>Covered Services for diagnosis and treatment of infertility (including lab and X-ray)</p> <p><i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i></p>	<p>50% Coinsurance See Additional Provisions</p>
<p>Intrauterine insemination (IUI)</p> <p><i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i></p>	<p>50% Coinsurance See Additional Provisions</p>
<p>In Vitro Fertilization (IVF)</p> <p><i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i></p>	<p>Not Covered</p>
<p>Gamete Intrafallopian Transfer (GIFT)</p> <p><i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i></p>	<p>Not Covered</p>
<p>Zygote Intrafallopian Transfer (ZIFT)</p> <p><i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i></p>	<p>Not Covered</p>

Mental Health Services	You Pay
Inpatient psychiatric hospitalization <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
• Inpatient day limit	Not Applicable
Outpatient individual therapy <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$30 Copayment each visit \$30 Copayment per partial hospitalization day Covered Services received during a visit: 20% Coinsurance
Outpatient group therapy <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: 50% of individual therapy Copayment 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 living outside the Service Area.	
Outpatient office visits <i>(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, preventive care and a visit with the administration of allergy injections. Office visits do not include: allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, hearing exams, home health visits, hospice services, immunizations and applied behavioral analysis (ABA).)</i> <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other Services: (Applies to Out-of-Pocket Maximum; Subject to medical Deductible)</i>	Visit: \$30 Copayment each visit Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
Diagnostic X-ray Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
Outpatient physical, occupational, and speech therapy visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: \$30 Copayment each visit Limited to 5 therapy visits (any combination) per Accumulation Period
Outpatient prescription drugs <i>(Not subject to pharmacy Deductible)</i> <i>(See "Prescription Drugs, Supplies, and Supplements" for medical Deductible and Out-of-Pocket Maximum information)</i>	See "Prescription Drugs, Supplies, and Supplements" for applicable Copayment or Coinsurance Limited to 5 prescription drug fills per Accumulation Period

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

You Pay

Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility

20% Coinsurance; Up to 60 days per condition per Accumulation Period

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Short-term outpatient physical, occupational and speech therapy visits

- Habilitative Services

(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)

\$30 Copayment each visit

Up to 20 visits per therapy per Accumulation Period

- Rehabilitative Services

(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)

\$30 Copayment each visit

Up to 20 visits per therapy per Accumulation Period

Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder

\$30 Copayment each visit

(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Applied Behavioral Services

- Applied Behavior Analysis (ABA)

(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)

\$30 Copayment each visit

Pulmonary rehabilitation

\$30 Copayment each visit

(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Prescription Drugs, Supplies, and Supplements

You Pay

Outpatient prescription drugs

(Prescriptions are not subject to the medical Deductible. Prescriptions are subject to the pharmacy Deductible except as otherwise listed in this "Prescription Drugs, Supplies and Supplements" section. Prescriptions: Do apply to Out-of-Pocket Maximum)

- Pharmacy Deductible

(Do apply to Out-of-Pocket Maximum)

Not Applicable

- Copayment/Coinsurance (except as listed below)

\$20 Generic/\$40 Brand/\$60 Non-Preferred

Contraceptive drugs at No Charge

- Preventive drugs on the Kaiser Permanente preventive drug list

Not Covered

- Specialty drugs

See applicable Outpatient prescription drug Copayment/Coinsurance

- Infertility drugs

Not Covered

- Prescribed supplies

20% Coinsurance

(When obtained from sources designated by Kaiser Permanente)

(Not subject to pharmacy Deductible)

- Sexual dysfunction drugs

Not Covered

- Over the counter items (OTC):

No Charge

(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)

(Not subject to pharmacy Deductible)

- Tobacco cessation drugs

No Charge

Supply Limit

- Day supply limit

30 days

- Mail-order supply limit

\$40 Generic/\$80 Brand/\$120 Non-Preferred

Up to 90 days

See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <ul style="list-style-type: none"> • Adult preventive care exams and screenings • Well-woman care exams and screenings • Well-child care exams • Immunizations 	No Charge
Colorectal cancer screenings <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <ul style="list-style-type: none"> • Colonoscopies • Flexible sigmoidoscopies 	No Charge No Charge
Non-preventive covered Services received in conjunction with preventive care exam <i>(See "Office Services" or "Laboratory Services" for medical Deductible and Out-of-Pocket Maximum information)</i>	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance
Reconstructive Surgery	You Pay
<i>(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information)</i>	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance
Skilled Nursing Facility Care	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance Up to 100 days per Accumulation Period
Transplant Services	You Pay
<i>(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information)</i>	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance
Vision Services and Optical	You Pay
Routine eye exam and refraction test when performed by an Optometrist <ul style="list-style-type: none"> • Members up to the end of the calendar year he/she turns age 19 <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> • Members age 19 and over <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	Visit: \$30 Copayment each visit Covered Services received during a visit: 20% Coinsurance Visit: \$30 Copayment each visit Covered Services received during a visit: 20% Coinsurance
Routine eye exam and refraction test when performed by an Ophthalmologist <ul style="list-style-type: none"> • Members up to the end of the calendar year he/she turns age 19 <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> • Members age 19 and over <i>Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	Visit: \$50 Copayment each visit Covered Services received during a visit: 20% Coinsurance Visit: \$50 Copayment each visit Covered Services received during a visit: 20% Coinsurance

Optical hardware	
<ul style="list-style-type: none"> Members up to the end of the calendar year he/she turns age 19 <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered
<ul style="list-style-type: none"> Members age 19 and over <i>(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	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) <i>(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	No Charge
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <ul style="list-style-type: none"> Diagnostic procedures include administered drugs Therapeutic procedures may incur an additional charge for administered drugs. <i>(See "Office Services" for "Office-administered Drugs")</i> 	20% Coinsurance 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.

HMO Plus	You Pay
Maximum limit per Accumulation Period	Not Applicable
<ul style="list-style-type: none"> Preventive care visits with a non-Plan Provider <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered
<ul style="list-style-type: none"> Primary care and allergy injection visits, outpatient mental health and chemical dependency individual therapy and short-term outpatient physical, occupational and speech therapy visits with a non-Plan Provider <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered
<ul style="list-style-type: none"> Specialty and gynecology care visits and allergy testing and evaluations with a non-Plan Provider <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered
<ul style="list-style-type: none"> Covered Services received during an office visit with a non-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services and X-ray special procedures <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
<ul style="list-style-type: none"> Outpatient prescription drugs filled at a non-Plan Pharmacy <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered
Outpatient prescription drugs prescribed by a non-Plan Provider and filled at a Plan Pharmacy <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	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 *Denver/Boulder* Members: **303-338-4545** or toll-free **1-800-218-1059**
Southern Colorado Members: **1-800-218-1059**
Northern Colorado Members: **970-207-7171** or toll-free **1-800-218-1059**
Mountain Colorado Members: **970-207-7171** 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 *Denver/Boulder* Members: **303-471-7700**
Southern Colorado Members: **1-866-702-9026**
Northern Colorado Members: **303-471-7700**
Mountain Colorado Members: **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 *Denver/Boulder* Members: **303-338-3800** or toll-free **1-800-632-9700**
Southern Colorado Members: **1-888-681-7878**
Northern Colorado Members: **1-844-201-5824**
Mountain Colorado Members: **1-844-837-6884**

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

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	<i>Denver/Boulder</i> Members: 303-338-3600 or toll-free 1-800-382-4661 <i>Southern Colorado</i> Members: 1-888-681-7878 <i>Northern Colorado</i> Members: 1-800-382-4661 <i>Mountain Colorado</i> Members: 1-844-837-6884
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	<i>Denver/Boulder</i> Members: Claims Department Kaiser Foundation Health Plan of Colorado P.O. Box 373150 Denver, CO 80237-3150 <i>Southern Colorado</i> Members: Claims Department Kaiser Foundation Health Plan of Colorado P.O. Box 372910 Denver, CO 80237-6910 <i>Northern Colorado</i> Members: Claims Department Kaiser Foundation Health Plan of Colorado P.O. Box 373150 Denver, CO 80237-3150 <i>Mountain Colorado</i> Members: Claims Department Kaiser Foundation Health Plan of 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
--------------	--

Patient Financial Services

CALL *Denver/Boulder* Members: **303-743-5900**
Southern Colorado Members: **1-888-681-7878**
Northern Colorado Members: **1-844-201-5824**
Mountain Colorado Members: **1-844-837-6884**

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

Personal Physician Selection Services

CALL *Denver/Boulder* Members: **303-338-4477**
Southern Colorado Members: **1-855-208-7221**
Northern Colorado Members: **1-855-208-7221**
Mountain Colorado Members: **1-855-208-7221**

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

WEBSITE kp.org/locations for a list of providers and facilities

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.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

TITLE PAGE (COVER PAGE)

CONTACT US

TABLE OF CONTENTS

I. ELIGIBILITY 1

A. Who Is Eligible 1

 1. General 1

 2. Subscribers 1

 3. Dependents 1

B. Enrollment and Effective Date of Coverage 1

 1. New Employees and their Dependents 1

 2. Members Who are Inpatient on Effective Date of Coverage 1

 3. Special Enrollment Due to Newly Acquired Dependents 1

 4. Special Enrollment 2

 5. Open Enrollment 2

 6. Persons Barred from Enrolling 2

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 2

A. Your Primary Care Provider 3

 1. Choosing Your Primary Care Provider 3

 2. Changing Your Primary Care Provider 3

B. Access to Other Providers 3

 1. Referrals and Authorizations 3

 2. Specialty Self-Referrals 4

 3. Second Opinions 5

C. Plan Facilities 5

 1. Denver/Boulder Service Area 5

 2. Southern, Northern, and Mountain Colorado Service Areas 5

D. Getting the Care You Need 5

E. Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas 5

F. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area 5

G. Using Your Health Plan Identification Card 6

H. Cross Market Access 6

 1. Denver/Boulder Members 6

 2. Southern, Northern, and Mountain Colorado Members 6

III. BENEFITS/COVERAGE (WHAT IS COVERED) 6

A. Office Services 6

B. Outpatient Hospital and Surgical Services 7

C. Hospital Inpatient Care 7

 1. Inpatient Services in a Plan Hospital 7

 2. Hospital Inpatient Care Exclusions 8

D. Ambulance Services 8

 1. Coverage 8

 2. Ambulance Services Exclusion 8

E. Chemical Dependency Services 8

 1. Inpatient Medical and Hospital Services 8

 2. Residential Rehabilitation 8

 3. Outpatient Services 8

 4. Chemical Dependency Services Exclusion 8

F. Clinical Trials (applies to non-grandfathered health plans only) 8

G. Dialysis Care 9

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics 9

 1. Durable Medical Equipment (DME) 9

2. Prosthetic Devices	10
3. Orthotic Devices	10
I. Early Childhood Intervention Services	10
1. Coverage	10
2. Limitations	10
3. Early Childhood Intervention Services Exclusions.....	10
J. Emergency Services and Urgent Care	11
1. Emergency Services.....	11
2. Urgent Care.....	12
K. Family Planning Services	12
1. Coverage.....	12
2. Family Planning Services Exclusions.....	12
L. Health Education Services	13
M. Hearing Services	13
1. Members up to Age 18	13
2. Members Age 18 Years and Older.....	13
N. Home Health Care	13
1. Coverage.....	13
2. Home Health Care Exclusions.....	13
O. Hospice Special Services and Hospice Care	13
1. Hospice Special Services	13
2. Hospice Care.....	14
P. Infertility Services.....	14
Q. Mental Health Services	14
1. Coverage	14
2. Mental Health Services Exclusions	14
R. Out-of-Area Benefit.....	15
1. Coverage.....	15
2. Out-of-Area Benefit Exclusions and Limitations	15
S. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	15
1. Coverage.....	15
2. Limitations.....	16
3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions.....	16
T. Prescription Drugs, Supplies, and Supplements.....	16
1. Coverage.....	16
2. Limitations.....	17
3. Prescription Drugs, Supplies, and Supplements Exclusions.....	17
U. Preventive Care Services	17
V. Reconstructive Surgery	18
1. Coverage.....	18
2. Reconstructive Surgery Exclusions	18
W. Skilled Nursing Facility Care.....	18
1. Coverage.....	18
2. Skilled Nursing Facility Care Exclusion.....	18
X. Transgender Services.....	18
Y. Transplant Services.....	18
1. Coverage.....	18
2. Related Prescription Drugs	19
3. Terms and Conditions.....	19
4. Transplant Services Exclusions and Limitations	19
Z. Vision Services	19
1. Coverage.....	19
2. Vision Services Exclusions.....	19
AA. X-ray, Laboratory, and X-ray Special Procedures	19
1. Coverage.....	19
2. X-ray, Laboratory, and X-ray Special Procedures Exclusions.....	20

IV.	LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)	20
A.	Exclusions.....	20
B.	Limitations.....	22
C.	Reductions	22
1.	Coordination of Benefits (COB).....	22
2.	Injuries or Illnesses Alleged to be Caused by Other Parties	25
3.	Surrogacy.....	26
V.	MEMBER PAYMENT RESPONSIBILITY	26
VI.	CLAIMS PROCEDURE (HOW TO FILE A CLAIM)	26
VII.	GENERAL POLICY PROVISIONS	27
A.	Access Plan.....	27
B.	Access to Services for Foreign Language Speakers	27
C.	Administration of Agreement	27
D.	Advance Directives.....	27
E.	Agreement Binding on Members.....	27
F.	Amendment of Agreement.....	27
G.	Applications and Statements.....	27
H.	Assignment	27
I.	Attorney Fees and Expenses	27
J.	Claims Review Authority	27
K.	Contracts with Plan Providers.....	28
L.	Deductible/Out-of-Pocket Maximum Takeover Credit	28
M.	Governing Law	28
N.	Group and Members are not Health Plan's Agents	28
O.	No Waiver.....	28
P.	Nondiscrimination	28
Q.	Notices	28
R.	Overpayment Recovery	28
S.	Privacy Practices.....	28
T.	Value-Added Services	29
U.	Women's Health and Cancer Rights Act.....	29
VIII.	TERMINATION/NONRENEWAL/CONTINUATION	29
A.	Termination Due to Loss of Eligibility	29
B.	Termination of Group Agreement	30
C.	Termination for Cause	30
D.	Termination for Nonpayment	30
E.	Termination of a Product or all Products (applies to non-grandfathered health plans only).....	30
F.	Rescission of Membership.....	30
G.	Continuation of Group Coverage Under Federal Law, State Law or USERRA	30
1.	Federal Law (COBRA).....	30
2.	State Law.....	30
3.	USERRA	31
H.	Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area.....	31
IX.	APPEALS AND COMPLAINTS	31
A.	Claims and Appeals	31
B.	Complaints.....	38
X.	INFORMATION ON POLICY AND RATE CHANGES	39
XI.	DEFINITIONS	39

ADDITIONAL PROVISIONS

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. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser Foundation Health Plan or allied plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. 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**.

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 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 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, sign on to kp.org/specialenrollment, or 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 your home Service Area, except as described under the following headings:

- "Emergency Services Provided by non-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.
- "Access to Other Providers" in this section.
- "Cross Market Access" in this section.

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the "Using Your Health Plan Identification Card" section.

Note: *Denver/Boulder* Members do not have access to Affiliated Providers within the *Denver/Boulder* Service Area unless authorized by Health Plan. *Southern, Northern, and Mountain Colorado* Members do have access to Affiliated Providers within their home Service Area.

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 within your home Service Area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the “Second Opinions” section.

a. Denver/Boulder Service Area

You may choose your PCP from our provider directory. To review a list of Plan Providers and their biographies, visit our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign in to your account online or call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

b. Southern, Northern, and Mountain Colorado Service Areas

You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the *Southern, Northern, and Mountain Colorado* Service Areas. You may choose your PCP from our panel of *Southern, Northern, and Mountain Colorado* providers.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of *Southern, Northern, and Mountain Colorado* Plan Providers by visiting our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

If you are seeking routine or specialty care in *Denver/Boulder*, you must have a referral from your local PCP with an Authorization from Health Plan. If you do not have an Authorization, you will be billed for the full amount of the office visit Charges. If you are visiting in the *Denver/Boulder* Service Area and need urgent or emergency care, you can visit a *Denver/Boulder* Plan Facility without a referral. For a referral from a specialist, see the “Access to Other Providers” section. For care in *Denver/Boulder* Plan Medical Offices, see “Cross Market Access”.

2. Changing Your Primary Care Provider

a. Denver/Boulder Service Area

Please call **Personal Physician Selection Services** 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. Southern, Northern, and Mountain Colorado Service Areas

Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Access to Other Providers

1. Referrals and Authorizations

a. Denver/Boulder Service Area

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will 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. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-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 by Health Plan and approved in advance. 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.

b. **Southern, Northern, and Mountain Colorado Service Areas**

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will 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. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-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 by Health Plan and approved in advance. 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 Self-Referrals**

a. **Denver/Boulder Service Area**

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. Female members do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Medical Group physician who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. 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**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-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.

b. **Southern, Northern, and Mountain Colorado Service Areas**

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. Female members do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Medical Group physician who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. 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**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-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.

Southern, Northern, and Mountain Colorado Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access" in this section).

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 Physician about any proposed covered Services.

C. Plan Facilities

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. Denver/Boulder Service Area

We offer health care at Plan Medical Offices conveniently located throughout the ***Denver/Boulder*** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home Service Area that will be most convenient for you.

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.

2. Southern, Northern, and Mountain Colorado Service Areas

When you select your PCP, you will receive your Services at that provider's office. You can find ***Southern, Northern, and Mountain Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from 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 a non-Plan Facility inside your Service Area is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside your Service Area, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside your 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 Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily, you can get visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, Copayments, Coinsurance, and Deductibles described in this EOC.

Please call **Member Services** to get more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may get visiting member care may change at any time.

You receive the same prescription drug benefit as your home service area benefit. This includes your Copayments or Coinsurance, exclusions and limitations.

F. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser Foundation Health Plan or allied plan service area in order to receive covered Services (except out-of-Plan Emergency Services and urgent care outside the Service Area). If you go to another Kaiser Foundation Health Plan or allied plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas" above.

G. 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, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

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.

H. Cross Market Access

Members may access certain Services at Kaiser Permanente Plan Medical Offices outside of their home Service Area.

1. Denver/Boulder Members

Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the *Southern, Northern, and Mountain Colorado* Service Areas. *Denver/Boulder* Members do not have access to Affiliated Providers in *Southern, Northern, and Mountain Colorado* unless authorized by Health Plan.

2. Southern, Northern, and Mountain Colorado Members

Southern, Northern, and Mountain Colorado Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the *Denver/Boulder, Southern, Northern, and Mountain Colorado* Service Areas. *Southern, Northern, and Mountain Colorado* Members do not have access to Affiliated Providers outside their home Service Area unless authorized by Health Plan.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; urgent care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Kaiser Permanente Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which Kaiser Permanente Plan Medical Offices you may receive Services please call **Member Services**.

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 specifically noted to the contrary in the following sections of this EOC: (a) “Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)” and (b) “Urgent Care Outside the Service Area” in “Emergency Services and Urgent Care”; 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 Self-Referrals”; and (b) “Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)” and “Urgent Care Outside the Service Area” in “Emergency Services and Urgent Care”; and
- You have met any Deductible requirements described in the “Schedule of Benefits (Who Pays What).”

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 (**Denver/Boulder** Members only).
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. Second opinion.
9. House calls when care can best be provided in your home as determined by a Plan Physician.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Telehealth and telemedicine visits.
13. Office-administered drugs.

Note: If the following are administered in a Plan Medical Office or during home visits if 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 your Office Services Copayment or Coinsurance.

Drugs 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 Medical Group's criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Outpatient 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 when administered in an outpatient setting:

1. Outpatient surgery at designated Plan Facilities, including an ambulatory surgical center, surgical suite, or outpatient hospital facility.
2. Outpatient hospital Services at designated outpatient hospital facilities, including but not limited to: sleep study, stress test, pulmonary function test, treatment room, or 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 Medical Group's 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 Areas:

- 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 child birth 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 Physician 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 after your discharge 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 Medical Group’s 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

1. Coverage

We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

2. Ambulance Services Exclusion

Transportation by other than a licensed ambulance. This includes transportation by car, taxi, bus, gurney van, minivan and any other type of transportation, even if it is the only way to travel to a Plan Provider.

E. Chemical Dependency Services

1. Inpatient Medical and Hospital Services

We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. 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 Physician.

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 Physician.

We cover chemical dependency 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 the treatment of chemical dependency are covered as provided in the “Mental Health Services” section.

4. Chemical Dependency Services Exclusion

Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

F. Clinical Trials (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:

- 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 Plan Provider makes this determination.
 - b. You provide us with medical and scientific information establishing this determination.
- 3. 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.

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 through 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 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.

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.

G. 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 all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Health Plan; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover: equipment; training; and medical supplies required for home dialysis. See the “Schedule of Benefits (Who Pays What).”

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

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician 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.

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 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 or loss, when prescribed by a Plan Physician 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. Medical Group or 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 Physician 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 Physician, 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 Physician 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.”

I. 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 that are necessary as a result of an acute medical condition; or
- b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal “Individuals with Disabilities Act”; or
- c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

3. Early Childhood Intervention Services Exclusions

- a. Respite care;
- b. Non-emergency medical transportation;
- c. Service coordination, as defined by state or federal law; and
- d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

J. 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, 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 non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call **Member Services**.

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 non-Plan Providers (out-of-Plan Emergency Services)

“Out-of-Plan Emergency Services” are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient’s medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices 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 non-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 Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. 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 you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

ii. Emergency Services Limitation for non-Plan Providers

If you are admitted to a non-Plan Hospital, non-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. 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.

b. Emergency Services Exclusions

Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. 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.

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.”

2. Urgent Care

a. Urgent Care Provided by Plan Providers

i. Denver/Boulder Service Area

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, Health Plan may determine that urgent care can best be provided 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.

ii. Southern, Northern, and Mountain Colorado Service Areas

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, Health Plan may determine that urgent care can best be provided 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 your Service Area. Urgent care received from non-Plan Providers outside your Service Area is covered only if all of the following requirements are met:

- i. The care is required to prevent serious deterioration of your health; and
- ii. The need for care results from an unforeseen illness or injury when you are temporarily away from our Service Area; and
- iii. The care cannot be delayed until you return to our Service Area.

c. Payment for Urgent Care Outside the Service Area

Health Plan’s payment for covered urgent care Services outside the Service Area is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

- i. does not exceed most Charges which providers in the same area charge for that Service; and
- ii. does not exceed the usual Charge made by the provider for that Service; and
- iii. is in accordance with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

Note: In addition to any Copayment or Coinsurance, the Member is responsible for any amounts over usual, reasonable and customary charges.

Note: 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.”

K. Family Planning 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 Services Exclusions

- a. Donor semen or eggs.

- b. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
- c. 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.

L. 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.

M. 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.

N. Home Health Care

1. Coverage

We cover skilled nursing care, home health aide Services, 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 by a Plan Physician and administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
- d. only if a Plan Physician 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. Care that Medical Group 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.

O. 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 Physician 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 Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

- 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.

P. Infertility Services

Infertility Services are **not** covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the infertility benefit, see the “Schedule of Benefits (Who Pays What).”

Q. Mental Health Services

1. Coverage

We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

a. Outpatient Therapy

We cover: diagnostic evaluation; individual therapy; psychiatric treatment; crisis intervention and stabilization for acute episodes; and psychiatrically oriented child and teenage guidance counseling.

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 Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

Separate Coinsurance applies to Services of Plan Physicians and mental health professionals.

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. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.

- c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless Medically Necessary.
- d. Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
- e. Services which are custodial or residential in nature.

R. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser Foundation 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. Mental health visit.
 - vi. Chemical dependency visit.
 - vii. Visits with the administration of allergy injections.
- 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: lab, procedures, and office administered drugs and devices except for allergy injections.
- 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 exams, home health visits, hospice services, and immunizations.
- f. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
- g. Any and all Services not listed in the “Coverage” section of this benefit.

S. 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 or a Skilled Nursing 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 Physician 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 Physician and Medically Necessary, we cover:

- i. Outpatient physical, occupational, and speech therapy in a Plan Medical Office or other location approved by Health Plan. 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.

T. Prescription Drugs, Supplies, and Supplements

We use drug formularies. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees for our Members. Our committees are comprised of Plan Physicians, pharmacists and a nurse practitioner. The committees select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, 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 Physician and obtained at Plan Pharmacies, or in the **Southern, Northern, and Mountain Colorado** Service Areas, at pharmacies designated by Health Plan. 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: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

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 are not licensed to mail medications out of state. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians 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 have a significant potential for waste and diversion. Those drugs are not available by mail-order service. 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 an 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.

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. Individual 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. (*Denver/Boulder, Northern, and Mountain Colorado* Members only)
- 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”.

U. 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 Copayment and Coinsurance for those Services.

V. 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.

W. Skilled Nursing Facility Care

1. Coverage

We cover skilled inpatient Services in a licensed Skilled Nursing Facility. 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.

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 medical criteria developed by Medical Group 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 Physicians 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 Physician 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 Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.
- c. A Plan Physician 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 Physician 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 Medical Group or a Plan Physician refers you to a non-Plan 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 Physician 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 Health Plan Medical Offices.

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. 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).
- e. Orthoptic (eye training) 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 and laboratory tests, Services and other materials, which includes but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds.
- ii. Therapeutic X-ray Services and materials
- iii. 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. **Certain Exams and Services.** Physical exams and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
 - a. Employment;
 - b. Participation in employee programs;
 - c. Insurance;
 - d. Disability;
 - e. Licensing; or
 - f. On court order or for parole or probation.
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. **Custodial 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.
5. **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 Physician, 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 Physician 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 and, unless otherwise specified herein, (a) and (b) are received at a Plan Facility or Skilled Nursing Facility.

The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.
6. **Directed Blood Donations.**
7. **Disposable Supplies.** Disposable 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.
8. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.
9. **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.
10. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.
11. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.
12. **Intermediate Care.** Care in an intermediate care facility.
13. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

14. **Services for Members in the Custody of Law Enforcement Officers.** Non-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.
15. **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.
16. **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.
17. **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 Medical Group refers you to a non-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.
18. **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.
19. **Weight Management Facilities.** Services received in a weight management facility.
20. **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 Physicians 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 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 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.
 - ii. If a person is covered by 2 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 2 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 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. 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.
 - i. There is an exception: 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. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - 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 primary and the plan that covers the person as a dependent is secondary. 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 secondary and the other plan is primary.
 - 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 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 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.

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.

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 a third 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 third 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 other party, regardless of whether the other party admits fault. Proceeds of such judgment 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 a third party, 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 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 or conservator asserts a claim against a third party based on your injury or illness, 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.

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 a third party. 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. Surrogacy

In situations where you receive monetary compensation to act as a 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.

Note: This "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) 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, LLC
Attn: 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 non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered 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 non-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 Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians 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 non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered 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/Coverage (What is Covered) ("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 about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the notice at your local 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 the Member 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 only 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:

1. Quarterly member magazine; or
2. 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 Dues.

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 Dues, 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 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 Physician 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 Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Dues, Health Plan may require payment of any outstanding Dues 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 Dues, 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 Dues 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 Dues, no later than 30 days after the date on which your Group coverage would otherwise terminate.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Dues 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 to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied 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 Health 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, dues, and Copayments or Coinsurance 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 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,
 - b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
 - c. uphold our previous adverse benefit determination when you appeal.
3. An **appeal** is a request for us to review our initial adverse benefit determination.

In addition, when we deny a request for medical care because it is excluded under this EOC, 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 benefit, then such evidence establishes that the denial is subject to the appeals process.

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.

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, kwijjigo holne' 303-338-3800.

Appointing a Representative

If you would like someone 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. 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).

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 benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. 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 to make a claim for 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 are already disabled, 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 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 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, if 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 the initial 15-day decision period, 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 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.

We will send written notice of our decision to you and, if applicable 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 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.

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 are already disabled, 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; or (c) your attending provider requests that your appeal be treated as urgent. 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 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 to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to 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 adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, 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 are already disabled, 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; or (c) your attending provider requests that your claim be treated as urgent. 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. If your authorized care ended before you submitted your claim, we will make our decision 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-day decision period ends 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 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 timeframe 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.

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), 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 review your appeal and send you a written decision as soon as possible if your 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 are already disabled, 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; or (c) your attending provider requests that your claim be treated as urgent. 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 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 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 180 days 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 **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 180 days 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 30 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 before the end of the initial 30-day decision period ends, 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. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

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 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.

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:

Within 30 days from the date of your receipt of our notice regarding your internal appeal. 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 mail your request to the **Appeals Program**.

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting. You may request to postpone this date, and your request cannot be unreasonably denied by Health Plan.

You may present your appeal in person before the 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. Please indicate in your appeal request how you want to present your appeal. 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 request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the 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 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 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 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 the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

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. 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 an existing 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 Medical Office, 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 Physician 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 Physicians. 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 Dues, 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 Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

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

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: 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.

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical condition 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; or
3. Serious dysfunction of any bodily organ or part.

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; and
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.

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 (habilitative services). 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: Health Plan and Medical Group.

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 or non-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 Dues. This EOC sometimes refers to a Member as “you” or “your.”

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 Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory, including any outpatient facility designated by Health Plan. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any 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 are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:

The **Denver/Boulder** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 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, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 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, 80252, 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, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80640, 80642, 80643.

The **Mountain Colorado** Service Area is that portion of Eagle, Garfield, Grand, Routt and Summit counties within the following zip codes: 80423, 80424, 80426, 80435, 80443, 80463, 80497, 80498, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658.

The **Northern Colorado** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82082.

The **Southern Colorado** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 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.

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).

Telehealth: A mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, 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. The term includes synchronous interactions and store-and-forward transfers. Telehealth does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

Telemedicine: The delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.

(This page intentionally left blank.)

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)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)

CHIROPRACTIC CARE

1. Coverage

Chiropractic Services are covered as shown on the “Schedule of Benefits (Who Pays What)” when provided by contracted providers. Coverage includes:

- a. Evaluation;
- b. Manual and manipulative therapy of the spinal and extraspinal regions.

You may self-refer for visits to contracted 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 (01-18)

**DURABLE MEDICAL EQUIPMENT (DME)
AND PROSTHETIC AND ORTHOTIC DEVICES**

When prescribed by a Plan Physician 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 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 a Member’s 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 Physician, 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 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. Medical Group or 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 Physician 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 Physician, 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 for treatment of cleft lip and cleft palate, as described above.
- 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 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 accord 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 Physician, unless the Member is 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 orthotic devices.
- vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)

INFERTILITY 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 the pharmacy for IUI.

2. Limitations

- a. IUI coverage is limited to three (3) treatment cycles per lifetime.
- 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. Donor semen or eggs.
- c. Any and all Services, supplies, office administered drugs, and prescription drugs received from the pharmacy related to the procurement and/or storage of semen and/or eggs, except as listed in the “Coverage” section of this benefit.
- d. Prescription drugs received from the pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
- e. Any and all Services, supplies, office administered drugs, and prescription drugs received from the 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 Infertility 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 (01-18)

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 Physician. 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 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 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 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 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 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.
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 of adults and tobacco cessation interventions by your primary care provider.
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 (01-18)

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.

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. Kaiser Permanente 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 that are not listed as generic in the then-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 Physician and obtained at Plan Pharmacies; or
- b. Physician to whom a Member has been referred by a Plan Physician 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. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. 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 Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, you pay only the brand-name Copayment or Coinsurance.
- b. Insulin.
- c. Compounded medications.
- d. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.

2. Limitations
 - a. Some drugs may require prior authorization.
 - b. We may apply Step Therapy to certain drugs. You or your Plan Provider may request an 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.
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.
(*Denver/Boulder, Northern Colorado, and Mountain Colorado* Members only)
 - 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. Individual 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 (01-18)

NOTES

NOTES

**Kaiser Foundation Health
Plan of Colorado**
2500 S. Havana St.
Aurora, CO 80014-1622

436 *****AUTO**ALL FOR AADC 800

T1 P1 019004545493



CITY AND COUNTY OF DENVER



Important plan information

EXHIBIT A
KAISER FOUNDATION HEALTH PLAN
OF COLORADO

Evidence of Coverage – High Deductible Health Plan (HDHP)

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 2018 contract year.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as “Kaiser Permanente,” “Health 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.

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 the number provided below.

Colorado 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 with the Kaiser Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, telephone number: 1-800-632-9700. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. 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

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or this notice requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.
Colorado 1-800-632-9700 (TTY 711)

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሲር ፐርማኒንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የሰልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውሎ ከአስተርጓሚ ጋር ይነጋገሩ።
Colorado 1-800-632-9700 (TTY 711)

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو يتطلب هذا الإشعار منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.
Colorado 1-800-632-9700 (TTY 711)

Bàsòò Wùdù (Bassa): M bédé dyí-bèdèin-dèò bé m ké gbo-kpá-kpá dyé dé m bídí-wùdùün bó pídyi. ɔ jù ké m dyi dyi-dieñ-dè bé bédé bá ni dè-mó-difèdèò dyí, mɔɔ bá ni kùün kpɔ jè dyí dyiìn dé Kaiser Permanente mú, mɔɔ ɔ jù ké bɔi-po-po nià ke dyi níin m me nyùin dè dò wé jéé dò kɔe ni, nií, dá nòbà bé wa tòà bó ni gbèè vèné mɔɔ ni gbèè dyùò jèe bé m ké wuɔu-zìin-nyò dò gbo wùdù.
Colorado 1-800-632-9700 (TTY 711)

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。
Colorado 1-800-632-9700 (TTY 711)

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.
Colorado 1-800-632-9700 (TTY 711)

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.
Colorado 1-800-632-9700 (TTY 711)

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asụsụ gi na akwụghị ugwo ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachọihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ na ọkwa a chọrọ ka ị mee ihe tupu otu ubochi, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi iji kwukọrịta okwu n'etiti onye ọkọwa okwu.
Colorado 1-800-632-9700 (TTY 711)

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳と、お話しください。
Colorado 1-800-632-9700 (TTY 711)

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 일정 날짜까지 조취를 취해야 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.
Colorado 1-800-632-9700 (TTY 711)

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Naabeehó (Navajo): T'áá ni nizaad bee níká i' doolwoł doo bik'é asíníłáágoó éi bee náhaz'á. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinilaa, éi bína'ídíłkid doogo, éi doodago díí naaltsoos haa'ída yoolkáalgo hait'áoda i' dííłíł níłníigo éi nitsaa hahoodzojí éi doodago t'áá aadi nahós'a' di ata' dahalne'ígíí bich'í' hólne'go bee bił ahíł hodíílnih.

Colorado 1-800-632-9700 (TTY 711)

नेपाली (Nepali): तपाईंसंग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नुपरेमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Colorado 1-800-632-9700 (TTY 711)

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan beeksisi Kun guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu kan gaafatu yoo ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bibiluudhaan turjumaana haasofisiisi.

Colorado 1-800-632-9700 (TTY 711)

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

Colorado 1-800-632-9700 (TTY 711)

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо данное уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Colorado 1-800-632-9700 (TTY 711)

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o este aviso requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se le proporcionó para su estado o región para hablar con un intérprete.

Colorado 1-800-632-9700 (TTY 711)

Tagalog (Tagalog): Mayroon kang karapatan na kumuha ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o ang abisong ito ay nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap usap sa tagapagsalin.

Colorado 1-800-632-9700 (TTY 711)

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc thông báo này yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Colorado 1-800-632-9700 (TTY 711)

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti rí irànlọ́wọ́ gbà nípa èdè rẹ láìsan owó. Bí o bá ní ìbèèrè nípa ìṣàfilọ̀lẹ̀ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ifitọ̀nilétí yìí fẹ́ kí gbé ìgbésẹ̀ kan ní ojú kan patọ́, pé nọmbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ láti bá òngbifọ̀ kan sọrọ̀.

Colorado 1-800-632-9700 (TTY 711)

CITY AND COUNTY OF DENVER
EVIDENCE OF COVERAGE AMENDMENT - 2018

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, step-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 both: career service employees as defined in section 9.1.1(e) of the charter, and appointed charter officers as defined in section 9.2.1(B) 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, 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.

(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. 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. A Plan Physician ***must*** determine that the Service is ***Medically Necessary*** to prevent, diagnose, or treat your medical condition. A Service is Medically Necessary ***only*** if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; ***and***
 - b. The Service ***must be*** provided, prescribed, authorized, or directed by a Plan Physician; ***and***
 - c. The Service ***must be a covered*** Service described in this EOC.
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.
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. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. 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.
7. 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.
8. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.

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 over usual, reasonable and customary 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 over usual, reasonable and customary 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 send you 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**.

Benefits for CITY AND COUNTY OF DENVER

75 - 015

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)

\$1,350/Individual per Accumulation Period

\$2,700/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

\$2,700/Individual per Accumulation Period

\$5,400/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 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Specialty care visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Consultations with clinical pharmacists 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Allergy evaluation and testing 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Allergy injections 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Gynecology care visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Routine prenatal and postpartum visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Office-administered drugs 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

• Travel immunizations Not Covered

Telemedicine

• Email

o Primary care visits No Charge

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

o Specialty care visits No Charge

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

• Online

o Primary care visits No Charge

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

o Specialty care visits No Charge

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

• Telephone

o Primary care visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

o Specialty care visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

• Video visits

o Primary care visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

o Specialty care visits 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

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 Medical Office 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

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 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Outpatient hospital Services 20% Coinsurance

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

Hospital Inpatient Care	You Pay
<i>(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services)</i>	20% Coinsurance
Inpatient professional Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Alternative Medicine	You Pay
Chiropractic care	
<ul style="list-style-type: none"> Evaluation and/or manipulation <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance each visit Up to 20 visits per Accumulation Period See Additional Provisions
<ul style="list-style-type: none"> Laboratory Services or x-rays required for chiropractic care <i>(See "X-ray, Laboratory, and X-ray Special Procedures" for medical Deductible and Out-of-Pocket Maximum information)</i> 	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance
Acupuncture Services <i>(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Ambulance Services	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Bariatric Surgery	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Not Covered Includes inpatient and outpatient covered Services
Chemical Dependency Services	You Pay
Inpatient medical detoxification <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Inpatient professional Services for medical detoxification <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Outpatient individual therapy <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance including partial hospitalization
Outpatient group therapy <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Residential rehabilitation <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance per inpatient admission
Dental Services following Accidental Injury	You Pay
<i>(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Dialysis Care	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	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

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.

Plan and non-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 may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.

Urgent care outside Service Area

(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)

20% Coinsurance

Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.

Covered only if all the following requirements are met:

- The care is required to prevent serious decline of health
 - The need for care results from an unforeseen illness or injury when temporarily away from our Service Area
 - The care cannot be delayed until you return to our Service Area
-

Family Planning 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 "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 <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Hearing aids for Members up to age 18 <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
<ul style="list-style-type: none"> Fitting and Recheck visits <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance
Hearing aids for Members age 18 and over <i>(If covered: Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Not Covered
<ul style="list-style-type: none"> Fitting and Recheck visits <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	Not Covered
Home Health Care	You Pay
Home health Services prescribed by a Plan Physician <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Hospice care for terminally ill patients <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Infertility Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Not Covered
Intrauterine insemination (IUI) <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Not Covered
In Vitro Fertilization (IVF) <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Gamete Intrafallopian Transfer (GIFT) <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Zygote Intrafallopian Transfer (ZIFT) <i>(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Not Covered
Mental Health Services	You Pay
Inpatient psychiatric hospitalization <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
<ul style="list-style-type: none"> Inpatient day limit 	Not Applicable
Inpatient professional Services for psychiatric hospitalization <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Outpatient individual therapy <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance including partial hospitalization
Outpatient group therapy <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 living outside the Service Area	
Outpatient office visits <i>(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, preventive care, and a visit with the administration of allergy injections. Office visits do not include: allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, hearing exams, home health visits, hospice services, immunizations, and applied behavioral analysis (ABA).)</i> <i>Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> <i>Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)</i>	Visit: 20% Coinsurance Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
Diagnostic X-ray Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
Outpatient physical, occupational, and speech therapy visits <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	Visit: 20% Coinsurance Limited to 5 therapy visits (any combination) per Accumulation Period
Outpatient prescription drugs <i>(See "Prescription Drugs, Supplies, and Supplements" for medical Deductible and Out-of-Pocket Maximum information)</i>	See "Prescription Drugs, Supplies, and Supplements" for applicable Copayment or Coinsurance Limited to 5 prescription drug fills per Accumulation Period
Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance; Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational and speech therapy visits <ul style="list-style-type: none"> • Habilitative Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> • Rehabilitative Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance Up to 20 visits per therapy per Accumulation Period 20% Coinsurance Up to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Applied Behavioral Services <ul style="list-style-type: none"> • Applied Behavior Analysis (ABA) <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance
Pulmonary rehabilitation <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	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.)

- Pharmacy Deductible

- Infertility drugs

- Over the counter items (OTC):

(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)

(Not subject to medical Deductible)

- Tobacco cessation drugs

- Prescribed supplies

(When obtained from sources designated by Kaiser Permanente)

(Not subject to pharmacy Deductible)

- Sexual dysfunction drugs

- Preventive drugs on the Kaiser Permanente preventive drug list

- Specialty drugs

\$10 Generic/\$35 Brand name/\$60
Non-Preferred

Contraceptive drugs at No Charge

Not Applicable

Not Covered

No Charge

No Charge

20% Coinsurance

Not Covered

See applicable Outpatient
prescription drug
Copayment/Coinsurance

See applicable Outpatient
prescription drug
Copayment/Coinsurance

Supply Limit

- Day supply limit

- Mail-order supply limit

30 days

\$20 Generic/\$70 Brand/\$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

- Well-woman care exams and screenings

- Well-child care exams

- Immunizations

No Charge

Colorectal cancer screenings

(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)

- Colonoscopies

- Flexible sigmoidoscopies

No Charge

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

Skilled Nursing Facility Care	You Pay
<i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance Up to 100 days per Accumulation Period
Transplant Services	You Pay
<i>(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for medical Deductible and Out-of-Pocket Maximum information)</i>	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance
Vision Services and Optical	You Pay
Routine eye exam and refraction test when performed by an Optometrist	
<ul style="list-style-type: none"> Members up to the end of the calendar year he/she turns age 19 <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> Members age 19 and over <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance 20% Coinsurance
Routine eye exam and refraction test when performed by an Ophthalmologist	
<ul style="list-style-type: none"> Members up to the end of the calendar year he/she turns age 19 <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> Members age 19 and over <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> 	20% Coinsurance 20% Coinsurance
Optical hardware	
<ul style="list-style-type: none"> Members up to the end of the calendar year he/she turns age 19 <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i> Members age 19 and over <i>(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)</i> 	Not Covered Not Covered
X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Diagnostic X-ray Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
Therapeutic X-ray Services <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine <i>(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)</i>	20% Coinsurance
<ul style="list-style-type: none"> Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs. 	
<i>(See "Office Services" for "Office-administered Drugs")</i>	

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 *Denver/Boulder* Members: **303-338-4545** or toll-free **1-800-218-1059**
Southern Colorado Members: **1-800-218-1059**
Northern Colorado Members: **970-207-7171** or toll-free **1-800-218-1059**
Mountain Colorado Members: **970-207-7171** 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 *Denver/Boulder* Members: **303-471-7700**
Southern Colorado Members: **1-866-702-9026**
Northern Colorado Members: **303-471-7700**
Mountain Colorado Members: **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 *Denver/Boulder* Members: **303-338-3800** or toll-free **1-800-632-9700**
Southern Colorado Members: **1-888-681-7878**
Northern Colorado Members: **1-844-201-5824**
Mountain Colorado Members: **1-844-837-6884**

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

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 *Denver/Boulder* Members: 303-338-3600 or toll-free 1-800-382-4661
Southern Colorado Members: 1-888-681-7878
Northern Colorado Members: 1-800-382-4661
Mountain Colorado Members: 1-844-837-6884

TTY 711
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE *Denver/Boulder* Members:
Claims Department
Kaiser Foundation Health Plan of Colorado
P.O. Box 373150
Denver, CO 80237-3150
Southern Colorado Members:
Claims Department
Kaiser Foundation Health Plan of Colorado
P.O. Box 372910
Denver, CO 80237-6910
Northern Colorado Members:
Claims Department
Kaiser Foundation Health Plan of Colorado
P.O. Box 373150
Denver, CO 80237-3150
Mountain Colorado Members:
Claims Department
Kaiser Foundation Health Plan of 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

Patient Financial Services

CALL *Denver/Boulder* Members: **303-743-5900**
Southern Colorado Members: **1-888-681-7878**
Northern Colorado Members: **1-844-201-5824**
Mountain Colorado Members: **1-844-837-6884**

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

Personal Physician Selection Services

CALL *Denver/Boulder* Members: **303-338-4477**
Southern Colorado Members: **1-855-208-7221**
Northern Colorado Members: **1-855-208-7221**
Mountain Colorado Members: **1-855-208-7221**

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

WEBSITE kp.org/locations for a list of providers and facilities

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.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS (WHO PAYS WHAT)
TITLE PAGE (COVER PAGE)
CONTACT US
TABLE OF CONTENTS

I. ELIGIBILITY 1

A. Who Is Eligible 1

 1. General..... 1

 2. Subscribers..... 1

 3. Dependents 1

 4. Medicare Eligibility 1

 5. Health Savings Account Eligibility 1

B. Enrollment and Effective Date of Coverage 1

 1. New Employees and their Dependents 1

 2. Members Who are Inpatient on Effective Date of Coverage 2

 3. Special Enrollment Due to Newly Acquired Dependents 2

 4. Special Enrollment..... 2

 5. Open Enrollment..... 2

 6. Persons Barred from Enrolling 2

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 3

A. Your Primary Care Provider 3

 1. Choosing Your Primary Care Provider 3

 2. Changing Your Primary Care Provider..... 3

B. Access to Other Providers..... 3

 1. Referrals and Authorizations 3

 2. Specialty Self-Referrals 4

 3. Second Opinions 5

C. Plan Facilities..... 5

 1. Denver/Boulder Service Area..... 5

 2. Southern, Northern, and Mountain Colorado Service Areas 5

D. Getting the Care You Need 5

E. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area 6

F. Using Your Health Plan Identification Card 6

G. Cross Market Access..... 6

 1. Denver/Boulder Members..... 6

 2. Southern, Northern, and Mountain Colorado Members..... 6

III. BENEFITS/COVERAGE (WHAT IS COVERED) 6

A. Office Services..... 7

B. Outpatient Hospital and Surgical Services..... 7

C. Hospital Inpatient Care 7

 1. Inpatient Services in a Plan Hospital 7

 2. Hospital Inpatient Care Exclusions 8

D. Ambulance Services..... 8

 1. Coverage 8

 2. Ambulance Services Exclusion 8

E. Chemical Dependency Services 8

 1. Inpatient Medical and Hospital Services 8

 2. Residential Rehabilitation..... 8

 3. Outpatient Services 8

 4. Chemical Dependency Services Exclusion..... 8

F. Clinical Trials (applies to non-grandfathered health plans only) 8

G. Dialysis Care..... 9

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics 9

- 1. Durable Medical Equipment (DME) 9
- 2. Prosthetic Devices 10
- 3. Orthotic Devices 10
- I. Early Childhood Intervention Services 10**
 - 1. Coverage 10
 - 2. Limitations 10
 - 3. Early Childhood Intervention Services Exclusions 10
- J. Emergency Services and Urgent Care 11**
 - 1. Emergency Services 11
 - 2. Urgent Care 12
- K. Family Planning Services 12**
 - 1. Coverage 12
 - 2. Family Planning Services Exclusions 13
- L. Health Education Services 13**
- M. Hearing Services 13**
- N. Home Health Care 13**
 - 1. Coverage 13
 - 2. Home Health Care Exclusions 13
- O. Hospice Special Services and Hospice Care 14**
 - 1. Hospice Special Services 14
 - 2. Hospice Care 14
- P. Infertility Services 14**
- Q. Mental Health Services 14**
 - 1. Coverage 14
 - 2. Mental Health Services Exclusions 15
- R. Out-of-Area Benefit 15**
 - 1. Coverage 15
 - 2. Out-of-Area Benefit Exclusions and Limitations 15
- S. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services 15**
 - 1. Coverage 15
 - 2. Limitations 16
 - 3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions 16
- T. Prescription Drugs, Supplies, and Supplements 16**
 - 1. Coverage 16
 - 2. Limitations 17
 - 3. Prescription Drugs, Supplies, and Supplements Exclusions 18
- U. Preventive Care Services 18**
- V. Reconstructive Surgery 18**
 - 1. Coverage 18
 - 2. Reconstructive Surgery Exclusions 18
- W. Skilled Nursing Facility Care 18**
- X. Transgender Services 19**
- Y. Transplant Services 19**
 - 1. Coverage 19
 - 2. Related Prescription Drugs 19
 - 3. Terms and Conditions 19
 - 4. Transplant Services Exclusions and Limitations 19
- Z. Vision Services 19**
 - 1. Coverage 19
 - 2. Vision Services Exclusions 20
- AA. X-ray, Laboratory, and X-ray Special Procedures 20**
 - 1. Coverage 20
 - 2. X-ray, Laboratory, and X-ray Special Procedures Exclusions 20
- IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED) 20**
 - A. Exclusions 20**

B.	Limitations	22
C.	Reductions	23
1.	Coordination of Benefits (COB).....	23
2.	Injuries or Illnesses Alleged to be Caused by Other Parties	26
3.	Surrogacy.....	26
V.	MEMBER PAYMENT RESPONSIBILITY	27
VI.	CLAIMS PROCEDURE (HOW TO FILE A CLAIM)	27
VII.	GENERAL POLICY PROVISIONS.....	27
A.	Access Plan	27
B.	Access to Services for Foreign Language Speakers.....	27
C.	Administration of Agreement	27
D.	Advance Directives	27
E.	Agreement Binding on Members	28
F.	Amendment of Agreement.....	28
G.	Applications and Statements.....	28
H.	Assignment	28
I.	Attorney Fees and Expenses	28
J.	Claims Review Authority	28
K.	Contracts with Plan Providers.....	28
L.	Deductible/Out-of-Pocket Maximum Takeover Credit.....	28
M.	Governing Law	29
N.	Group and Members are not Health Plan’s Agents.....	29
O.	No Waiver.....	29
P.	Nondiscrimination	29
Q.	Notices	29
R.	Overpayment Recovery	29
S.	Privacy Practices.....	29
T.	Value-Added Services	29
U.	Women’s Health and Cancer Rights Act	30
VIII.	TERMINATION/NONRENEWAL/CONTINUATION.....	30
A.	Termination Due to Loss of Eligibility	30
B.	Termination of Group Agreement.....	30
C.	Termination for Cause	30
D.	Termination for Nonpayment.....	31
E.	Termination of a Product or all Products (applies to non-grandfathered health plans only).....	31
F.	Rescission of Membership.....	31
G.	Continuation of Group Coverage Under Federal Law, State Law or USERRA	31
1.	Federal Law (COBRA).....	31
2.	State Law	31
3.	USERRA	31
H.	Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area.....	32
IX.	APPEALS AND COMPLAINTS.....	32
A.	Claims and Appeals	32
B.	Complaints	39
X.	INFORMATION ON POLICY AND RATE CHANGES	39
XI.	DEFINITIONS	39

ADDITIONAL PROVISIONS

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. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser Foundation Health Plan or allied plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. 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**.

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. Medicare Eligibility

This health plan is not intended for Members entitled to benefits under Medicare. If you are or become eligible for Medicare during the term of your Group's Agreement, and you enroll in Medicare Part A, Part B or Part D with Health Plan, or another Medicare Advantage health plan, you no longer qualify as an eligible individual for an HSA-qualifying High Deductible Health Plan.

5. 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 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 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, sign on to kp.org/specialenrollment, or 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 your home Service Area, except as described under the following headings:

- “Emergency Services Provided by non-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.
- “Access to Other Providers” in this section.
- “Cross Market Access” in this section.

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the “Using Your Health Plan Identification Card” section.

Note: *Denver/Boulder* Members do not have access to Affiliated Providers within the *Denver/Boulder* Service Area unless authorized by Health Plan. *Southern, Northern, and Mountain Colorado* Members do have access to Affiliated Providers within their home Service Area.

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 within your home Service Area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the “Second Opinions” section.

a. Denver/Boulder Service Area

You may choose your PCP from our provider directory. To review a list of Plan Providers and their biographies, visit our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign in to your account online or call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

b. Southern, Northern, and Mountain Colorado Service Areas

You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the *Southern, Northern, and Mountain Colorado* Service Areas. You may choose your PCP from our panel of *Southern, Northern, and Mountain Colorado* providers.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of *Southern, Northern, and Mountain Colorado* Plan Providers by visiting our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

If you are seeking routine or specialty care in *Denver/Boulder*, you must have a referral from your local PCP with an Authorization from Health Plan. If you do not have an Authorization, you will be billed for the full amount of the office visit Charges. If you are visiting in the *Denver/Boulder* Service Area and need urgent or emergency care, you can visit a *Denver/Boulder* Plan Facility without a referral. For a referral from a specialist, see the “Access to Other Providers” section. For care in *Denver/Boulder* Plan Medical Offices, see “Cross Market Access”.

2. Changing Your Primary Care Provider

a. Denver/Boulder Service Area

Please call **Personal Physician Selection Services** 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. Southern, Northern, and Mountain Colorado Service Areas

Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Access to Other Providers

1. Referrals and Authorizations

a. Denver/Boulder Service Area

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will 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. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-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 by Health Plan and approved in advance. 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.

b. **Southern, Northern, and Mountain Colorado Service Areas**

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will 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. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-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 by Health Plan and approved in advance. 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 Self-Referrals

a. **Denver/Boulder Service Area**

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. Female members do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Medical Group physician who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. 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**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-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.

b. **Southern, Northern, and Mountain Colorado Service Areas**

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. Female members do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Medical Group physician who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. 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**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-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.

Southern, Northern, and Mountain Colorado Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the **Denver/Boulder** Service Area (see "Cross Market Access" in this section).

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 Physician about any proposed covered Services.

C. **Plan Facilities**

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. **Denver/Boulder Service Area**

We offer health care at Plan Medical Offices conveniently located throughout the **Denver/Boulder** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home Service Area that will be most convenient for you.

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.

2. **Southern, Northern, and Mountain Colorado Service Areas**

When you select your PCP, you will receive your Services at that provider's office. You can find **Southern, Northern, and Mountain Colorado** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from 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 a non-Plan Facility inside your Service Area is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside your Service Area, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside your 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. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements.

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, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

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.

G. Cross Market Access

Members may access certain Services at Kaiser Permanente Plan Medical Offices outside of their home Service Area.

1. Denver/Boulder Members

Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the **Southern, Northern, and Mountain Colorado** Service Areas. **Denver/Boulder** Members do not have access to Affiliated Providers in **Southern, Northern, and Mountain Colorado** unless authorized by Health Plan.

2. Southern, Northern, and Mountain Colorado Members

Southern, Northern, and Mountain Colorado Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the **Denver/Boulder, Southern, Northern, and Mountain Colorado** Service Areas. **Southern, Northern, and Mountain Colorado** Members do not have access to Affiliated Providers outside their home Service Area unless authorized by Health Plan.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; urgent care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which Kaiser Permanente Plan Medical Offices you may receive Services, please call **Member Services**.

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 specifically noted to the contrary in the following sections of this EOC: (a) “Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)” and (b) “Urgent Care Outside the Service Area” in “Emergency Services and Urgent Care”; 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 Self-Referrals”; and (b) “Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)” and “Urgent Care Outside the Service Area” in “Emergency Services and Urgent Care”; and
- You have met any Deductible requirements described in the “Schedule of Benefits (Who Pays What).”

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 (*Denver/Boulder* Members only).
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. Second opinion.
9. House calls when care can best be provided in your home as determined by a Plan Physician.
10. Medical social Services.
11. Preventive care Services (see “Preventive Care Services” in this “Benefits/Coverage (What is Covered)” section for more details).
12. Telehealth and telemedicine visits.
13. Office-administered drugs.

Note: If the following are administered in a Plan Medical Office or during home visits if 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 your Office Services Copayment or Coinsurance.

Drugs 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 Medical Group’s criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Outpatient 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 when administered in an outpatient setting:

1. Outpatient surgery at designated Plan Facilities, including an ambulatory surgical center, surgical suite, or outpatient hospital facility.
2. Outpatient hospital Services at designated outpatient hospital facilities, including but not limited to: sleep study, stress test, pulmonary function test, treatment room, or 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 Medical Group’s 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 Areas:

- 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 child birth 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 Physician 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 after your discharge 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 Medical Group's 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

1. Coverage

We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

2. Ambulance Services Exclusion

Transportation by other than a licensed ambulance. This includes transportation by car, taxi, bus, gurney van, minivan and any other type of transportation, even if it is the only way to travel to a Plan Provider.

E. Chemical Dependency Services

1. Inpatient Medical and Hospital Services

We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. 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 Physician.

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 Physician.

We cover chemical dependency 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 the treatment of chemical dependency are covered as provided in the "Mental Health Services" section.

4. Chemical Dependency Services Exclusion

Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

F. Clinical Trials (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:

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 Plan Provider makes this determination.
 - b. You provide us with medical and scientific information establishing this determination.
3. 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.
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 through 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 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.

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.

G. 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 all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Health Plan; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover: equipment; training; and medical supplies required for home dialysis. See the “Schedule of Benefits (Who Pays What).”

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

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician 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.

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 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 or loss, when prescribed by a Plan Physician 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. Medical Group or 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 Physician 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 Physician, 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 Physician 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.”

I. 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 that are necessary as a result of an acute medical condition; or
- b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal “Individuals with Disabilities Act”; or
- c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

3. Early Childhood Intervention Services Exclusions

- a. Respite care;
- b. Non-emergency medical transportation;

- c. Service coordination, as defined by state or federal law; and
- d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

J. 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, 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 non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call **Member Services**.

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 non-Plan Providers (out-of-Plan Emergency Services)

“Out-of-Plan Emergency Services” are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient’s medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices 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 non-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 Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. 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 you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

ii. Emergency Services Limitation for non-Plan Providers

If you are admitted to a non-Plan Hospital, non-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. 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.

b. Emergency Services Exclusions

Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. 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.

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.”

2. Urgent Care

a. Urgent Care Provided by Plan Providers

i. Denver/Boulder Service Area

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, Health Plan may determine that urgent care can best be provided 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.

ii. Southern, Northern, and Mountain Colorado Service Areas

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, Health Plan may determine that urgent care can best be provided 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 your Service Area. Urgent care received from non-Plan Providers outside your Service Area is covered only if all of the following requirements are met:

- i. The care is required to prevent serious deterioration of your health; and
- ii. The need for care results from an unforeseen illness or injury when you are temporarily away from our Service Area; and
- iii. The care cannot be delayed until you return to our Service Area.

c. Payment for Urgent Care Outside the Service Area

Health Plan’s payment for covered urgent care Services outside the Service Area is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

- i. does not exceed most Charges which providers in the same area charge for that Service; and
- ii. does not exceed the usual Charge made by the provider for that Service; and
- iii. is in accordance with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

Note: In addition to any Copayment or Coinsurance, the Member is responsible for any amounts over usual, reasonable and customary charges.

Note: 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.”

K. Family Planning 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 Services Exclusions

- a. Donor semen or eggs.
- b. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
- c. 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.

L. 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.

M. 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.

N. Home Health Care

1. Coverage

We cover skilled nursing care, home health aide Services, 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 by a Plan Physician and administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
- d. only if a Plan Physician 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. Care that Medical Group 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.

O. 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 Physician 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 Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

- 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.

P. Infertility Services

Infertility Services are **not** covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the infertility benefit, see the “Schedule of Benefits (Who Pays What).”

Q. Mental Health Services

1. Coverage

We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

a. Outpatient Therapy

We cover: diagnostic evaluation; individual therapy; psychiatric treatment; crisis intervention and stabilization for acute episodes; and psychiatrically oriented child and teenage guidance counseling.

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 Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

Separate Coinsurance applies to Services of Plan Physicians and mental health professionals.

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. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.
- c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless Medically Necessary.
- d. Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
- e. Services which are custodial or residential in nature.

R. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser Foundation 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. Mental health visit.
 - vi. Chemical dependency visit.
 - vii. Visits with the administration of allergy injections.
- 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**: lab, procedures, and office administered drugs and devices except for allergy injections.
- 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 exams, home health visits, hospice services, and immunizations.
- f. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
- g. Any and all Services not listed in the “Coverage” section of this benefit.

S. 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 or a Skilled Nursing 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 Physician 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 Physician and Medically Necessary, we cover:

- i. Outpatient physical, occupational, and speech therapy in a Plan Medical Office or other location approved by Health Plan. 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.

T. Prescription Drugs, Supplies, and Supplements

We use drug formularies. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees for our Members. Our committees are comprised of Plan Physicians, pharmacists and a nurse practitioner. The committees select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, 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. Coveragea. 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 Physician and obtained at Plan Pharmacies, or in the **Southern, Northern, and Mountain Colorado** Service Areas, at pharmacies designated by Health Plan. 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: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

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 are not licensed to mail medications out of state. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians 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 have a significant potential for waste and diversion. Those drugs are not available by mail-order service. 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 an 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.

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. Individual 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. (*Denver/Boulder, Northern, and Mountain Colorado* Members only).
- 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”.

U. 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 Copayment and Coinsurance for those Services.

V. 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.

W. Skilled Nursing Facility Care

1. Coverage

We cover skilled inpatient Services in a licensed Skilled Nursing Facility. 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.

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 medical criteria developed by Medical Group 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 Physicians 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 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 Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.
- c. A Plan Physician 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 Physician 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 Medical Group or a Plan Physician refers you to a non-Plan 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 Physician 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 Health Plan Medical Offices.

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. 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).
 - e. Orthoptic (eye training) 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 and laboratory tests, Services and materials, which includes but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds.
 - ii. Therapeutic X-ray Services and materials.
 - iii. 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. **Certain Exams and Services.** Physical exams and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
 - a. Employment;
 - b. Participation in employee programs;
 - c. Insurance;
 - d. Disability;
 - e. Licensing; or
 - f. On court order or for parole or probation.

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. **Custodial 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.
5. **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 Physician, 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 Physician 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 and, unless otherwise specified herein, (a) and (b) are received at a Plan Facility or Skilled Nursing Facility.

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

6. **Directed Blood Donations.**
7. **Disposable Supplies.** Disposable 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.
8. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.
9. **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.

- 10. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.
- 11. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased supplemental coverage.
- 12. **Intermediate Care.** Care in an intermediate care facility.
- 13. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
- 14. **Services for Members in the Custody of Law Enforcement Officers.** Non-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.
- 15. **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.
- 16. **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.
- 17. **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 Medical Group refers you to a non-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.
- 18. **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.
- 19. **Weight Management Facilities.** Services received in a weight management facility.
- 20. **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 Physicians 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 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 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.
- ii. If a person is covered by 2 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 2 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 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. 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.
 - i. There is an exception: 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. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - 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 primary and the plan that covers the person as a dependent is secondary. 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 secondary and the other plan is primary.
 - 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 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 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.

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.

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 a third 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 third 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 other party, regardless of whether the other party admits fault. Proceeds of such judgment 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 a third party, 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 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 or conservator asserts a claim against a third party based on your injury or illness, 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.

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 a third party. 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. Surrogacy

In situations where you receive monetary compensation to act as a 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.

Note: This "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) 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, LLC
Attn: 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 non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered 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 non-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 Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians 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 non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered 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. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the notice at your local 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 the Member 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 only 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:

1. Quarterly member magazine; or
2. 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 Dues.

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 Dues, 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 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 Physician 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 Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Dues, Health Plan may require payment of any outstanding Dues 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 Dues, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA1. 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 Dues 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 Dues, no later than 30 days after the date on which your Group coverage would otherwise terminate.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Dues 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 to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied 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, Dues, Copayments and Coinsurance 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 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,
 - b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
 - c. uphold our previous adverse benefit determination when you appeal.
3. An **appeal** is a request for us to review our initial adverse benefit determination.

In addition, when we deny a request for medical care because it is excluded under this EOC, 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 benefit, then such evidence establishes that the denial is subject to the appeals process.

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.

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, kwijigo holne' 303-338-3800.

Appointing a Representative

If you would like someone 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. 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).

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 benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. 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 to make a claim for 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 are already disabled, 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 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 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, if 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 the initial 15-day decision period, 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 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.

We will send written notice of our decision to you and, if applicable 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 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.

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 are already disabled, 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; or (c) your attending provider requests that your appeal be treated as urgent. 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 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 to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to 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 adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, 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 are already disabled, 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; or (c) your attending provider requests that your claim be treated as urgent. 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. If your authorized care ended before you submitted your claim, we will make our decision 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-day decision period ends 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 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 timeframe 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.

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), 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 review your appeal and send you a written decision as soon as possible if your 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 are already disabled, 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; or (c) your attending provider requests that your claim be treated as urgent. 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 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 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 180 days 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 **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 180 days 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 30 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 before the end of the initial 30-day decision period ends, 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. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

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 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.

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:

Within 30 days from the date of your receipt of our notice regarding your internal appeal. 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 mail your request to the **Appeals Program**.

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting. You may request to postpone this date, and your request cannot be unreasonably denied by Health Plan.

You may present your appeal in person before the 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. Please indicate in your appeal request how you want to present your appeal. 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 request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the 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 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 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 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 the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse decision letter regarding you 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. 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 an existing 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 Medical Office, 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 Physician 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 Physicians. 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 Dues, 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 Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

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

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: 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.

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical condition 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; or
3. Serious dysfunction of any bodily organ or part.

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; and
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.

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 (habilitative services). 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: Health Plan and Medical Group

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 or non-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 Dues. This EOC sometimes refers to a Member as “you” or “your.”

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 Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory, including any outpatient facility designated by Health Plan. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any 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 are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:

The **Denver/Boulder** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 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, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 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, 80252, 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, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80640, 80642, 80643.

The **Mountain Colorado** Service Area is that portion of Eagle, Garfield, Grand, Routt and Summit counties within the following zip codes: 80423, 80424, 80426, 80435, 80443, 80463, 80497, 80498, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658.

The **Northern Colorado** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82082.

The **Southern Colorado** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 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.

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).

Telehealth: A mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, 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. The term includes synchronous interactions and store-and-forward transfers. Telehealth does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

Telemedicine: The delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.

(This page intentionally left blank.)

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)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)

CHIROPRACTIC CARE

1. Coverage

Chiropractic Services are covered as shown on the “Schedule of Benefits (Who Pays What)” when provided by contracted providers. Coverage includes:

- a. Evaluation;
- b. Manual and manipulative therapy of the spinal and extraspinal regions.

You may self-refer for visits to contracted 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 (01-18)

**DURABLE MEDICAL EQUIPMENT (DME)
AND PROSTHETIC AND ORTHOTIC DEVICES**

When prescribed by a Plan Physician 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 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 a Member’s 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 Physician, 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 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. Medical Group or 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 Physician 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 Physician, 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 for treatment of cleft lip and cleft palate, as described above.
- 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 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 accord 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 Physician, unless the Member is 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 orthotic devices.
- vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)

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 Physician. 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 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 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 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 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 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.
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 of adults and tobacco cessation interventions by your primary care provider.
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 (01-18)

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.

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. Kaiser Permanente 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 that are not listed as generic in the then-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 Physician and obtained at Plan Pharmacies; or
- b. Physician to whom a Member has been referred by a Plan Physician 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. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. 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 Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, you pay only the brand-name Copayment or Coinsurance.
- b. Insulin.
- c. Compounded medications.
- d. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.

2. Limitations
 - a. Some drugs may require prior authorization.
 - b. We may apply Step Therapy to certain drugs. You or your Plan Provider may request an 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.
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.
(Denver/Boulder, Northern Colorado, and Mountain Colorado Members only)
 - 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. Individual 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 (01-18)

**Kaiser Foundation Health
Plan of Colorado**
2500 S. Havana St.
Aurora, CO 80014-1622

16015 *****AUTO**5-DIGIT 80232

P-2 P15 019004559931



CITY AND COUNTY OF DENVER



Important plan information

EXHIBIT A

KAISER FOUNDATION HEALTH PLAN

OF COLORADO

Evidence of Coverage – Medicare Benefits and Services, and
Prescription Drug Coverage for Senior Advantage Group Plan
(HMO)

Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Kaiser Permanente Senior Advantage Group Plan (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage during your group's 2018 contract year. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of Colorado (Health Plan). When this Evidence of Coverage says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This document is available for free in Spanish. Please contact our Member Services number at **1-800-476-2167** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **1-800-476-2167**. (Los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a. m. a 8 p. m., siete días a la semana.

This document is available in Braille, large print, or CD if you need it by calling Member Services (phone numbers are printed on the back cover of this booklet).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2019, and at other times in accordance with your group's agreement with us.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

CITY AND COUNTY OF DENVER
EVIDENCE OF COVERAGE AMENDMENT - 2018


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, step-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 both: career service employees as defined in section 9.1.1(e) of the charter, and appointed charter officers as defined in section 9.2.1(B) 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, 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.

(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)





Medical Benefits Chart: Kaiser Permanente Group Senior Advantage (HMO)

**CITY AND COUNTY OF DENVER
75 - 013**

Services that are covered for you	What you must pay when you get these covered services
Annual out-of-pocket maximum	\$2,500/Individual per year
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Alternative therapies *	
Acupuncture	Not Covered
Ambulance services <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by our plan. • We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if one of the following is true: <ul style="list-style-type: none"> ◆ You reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. ◆ Your treating physician determines that you must be transported to another facility because your emergency medical condition is not stabilized and the care you need is not available at the treating facility. ◆ You may need to file a claim for reimbursement unless the provider agrees to bill us (see Chapter 7). <p>† Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.</p>	20% Coinsurance Up to \$195 per trip




† **Your provider must obtain prior authorization from our plan.**

* **Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
<p> Annual routine physical exams</p> <p>Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. This exam is covered once every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for this preventive care.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p> Bone-mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months. 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>



†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Cardiac rehabilitation services†</p> <p>Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.</p> <p>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	
<p>Individual therapy visits.</p>	<p>\$15 Copayment each visit or \$30 Copayment each visit Copayment dependent upon provider type</p>
<p>Group therapy visits.</p>	<p>Your primary care office visit copayment or \$10, whichever is less.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for this cardiovascular disease testing that is covered once every five years.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months. 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>



†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Chiropractic services Covered services include:</p> <ul style="list-style-type: none"> We cover only Medicare-covered manual manipulation of the spine to correct subluxation. These Medicare-covered services are provided by a participating chiropractor. Please refer to the Provider Directory. <p>If purchased by your group, supplemental chiropractic services.</p> <p>Laboratory Services or X-rays required for Chiropractic care</p>	<p>\$15 Copayment each visit Up to 20 visits per year See Additional Provisions</p> <p>See X-ray</p>
<p> Colorectal cancer screening</p> <ul style="list-style-type: none"> For people 50 and older, the following are covered: <ul style="list-style-type: none"> Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. One of the following every 12 months: <ul style="list-style-type: none"> Guaiac-based fecal occult blood test (gFOBT). Fecal immunochemical test (FIT). DNA-based colorectal screening every 3 years. For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy. 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p>Dental services (from designated providers)*</p>	<p>Please see the Additional Provisions in the back of this booklet to see if your group has purchased coverage for dental services.</p>
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p>Diabetes self-management, training and diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users), covered services include:</p> <ul style="list-style-type: none"> • †Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. 	<p>No charge</p>
<ul style="list-style-type: none"> • †For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. 	<p>No Charge</p>
<ul style="list-style-type: none"> •  Diabetes self-management training is covered under certain conditions. <p>Note: You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare. †</p>	<p>\$15 Copayment each visit or \$30 Copayment each visit copayment dependent upon provider</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Durable medical equipment (DME) and related supplies†</p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at kp.org/directory.</p>	<p>No Charge</p> <p>See Additional Provisions</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>You have worldwide emergency care coverage.</p>	<p>\$65 Copayment each visit</p> <p>Includes X-ray special procedures.</p> <p>This copayment does not apply if you are immediately admitted to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation).</p> <p>†If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.</p>


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Fitness benefit*</p> <p>A health and fitness benefit is provided through Healthways SilverSneakers® Fitness Program that includes the following:</p> <ul style="list-style-type: none"> • A basic fitness membership with access to all participating fitness locations and their basic amenities. • SilverSneakers® group fitness classes, taught by certified instructors that focus on cardiovascular health, muscle strengthening, flexibility, agility, balance, and coordination. • Health education events and social activities focused on overall well-being. • Access to www.silversneakers.com/member, a secure online community for members only, with wellness advice and fitness support information. • SilverSneakers® Steps, a self-directed fitness program for members without convenient access to SilverSneakers® fitness locations, which includes tools and resources to help you get fit at home or on the go. <p>The following are not covered: programs, services, and facilities that carry additional charges, such as racquetball, tennis, and some court sports, massage therapy, lessons related to recreational sports, tournaments, and similar fee-based activities.</p> <p>For more information about SilverSneakers® and the list of participating fitness locations in your area, call toll-free 1-888-423-4632 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. (EST) or visit www.silversneakers.com. Also, you can simply go to a participating fitness location and show your Senior Advantage membership card to enroll in the program.</p>	<p>No charge</p>
<p>Hearing services</p>	
<p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>\$15 Copayment each visit</p>
<p>Hearing aids.</p>	<p>\$500 Credit per ear every 36 months See Additional Provisions</p>
<p>Fitting & Recheck visits</p>	<p>\$15 Copayment each visit</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam every 12 months.</p> <p>For women who are pregnant, we cover up to three screening exams during a pregnancy.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care†</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies. 	<p>No charge</p> <p>Note: There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.</p>
<p>Home infusion therapy†</p> <p>We cover home infusion supplies and drugs if all of the following are true:</p> <ul style="list-style-type: none"> • Your prescription drug is on our Medicare Part D formulary (or you have a formulary exception). • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy. 	<p>No charge</p>


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Hospice care†</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. <p>*For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • *If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). <p>For services that are covered by our plan but are not covered by Medicare Part A or B: We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p>For drugs that may be covered by our plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4, "What if you're in Medicare-certified hospice."</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Hospice care for members without Part A†</p> <p>For members without Part A, the hospice benefit described earlier in this section does not apply to members who are not enrolled in Medicare Part A. Our plan, rather than Original Medicare, covers hospice care for members who are not enrolled in Medicare Part A. Members must receive hospice services from network providers.</p>	No charge
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
<p>Inpatient hospital care†</p>	
<p>Includes inpatient acute, inpatient rehabilitation, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification). 	<p>\$300 Copayment per admission</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p> <p>Note: If you are admitted to the hospital in 2017 and are not discharged until sometime in 2018, the 2017 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<ul style="list-style-type: none"> • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If we provide transplant services at a distant location (outside of the service area) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Note: Travel and lodging expenses must be authorized by Medical Group when a network physician refers you to an out-of-network provider outside our service area for transplant services. We will pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. For information specific to your situation, please contact your assigned Transplant Coordinator or call the Transplant Administrative Offices at 1-877-895-2705 (TTY users may call 711). • Blood - including storage and administration. • Physician services <p>Note: To be an “inpatient,” your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an “inpatient,” or an “outpatient,” you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, “<i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i>” This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
Inpatient substance abuse treatment†	
<ul style="list-style-type: none"> • Substance abuse inpatient medical detoxification. 	\$300 Copayment per admission
<ul style="list-style-type: none"> • Substance abuse inpatient rehabilitation. 	\$300 Copayment per inpatient admission



†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
Inpatient mental health care†	
Covered services include mental health care services that require a hospital stay. We cover up to 190-days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	\$300 Copayment per admission
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay†	
<p>If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the the hospital or SNF. Covered services include but are not limited to:</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings. • Splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition). • Physical therapy, speech therapy, and occupational therapy. 	<p>Medicare Part B medical services, will be covered as described under their respective benefit headings:</p> <ul style="list-style-type: none"> • Physician services, including doctor office visits. • Outpatient diagnostic tests and therapeutic services and supplies. • Prosthetic devices and related supplies. • Outpatient rehabilitation services. • Physical therapy, speech therapy, and occupational therapy.


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew his or her referral yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members-eligible for Medicare-covered medical nutrition therapy services.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Medicare Part B prescription drugs†</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually are not self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Antigens. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. 	<p>20% Coinsurance</p>
<ul style="list-style-type: none"> • Clotting factors you give yourself by injection if you have hemophilia. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p>	<p>You pay the same cost-sharing for these Part B drugs when dispensed through a network pharmacy as reflected in the prescription drug section below.</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Laboratory tests. • † Blood -including storage and administration. 	No charge.
<ul style="list-style-type: none"> • † Surgical supplies, such as dressings. • † Splints, casts, and other devices used to reduce fractures and dislocations. 	20% Coinsurance
<ul style="list-style-type: none"> • † X-rays. 	No Charge per x-ray
<ul style="list-style-type: none"> • † Other outpatient diagnostic tests — special procedures such as MRI, CT, PET scans and nuclear medicine. 	\$100 Copayment per procedure
<ul style="list-style-type: none"> • † Therapeutic X-rays 	\$30 Copayment
<p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	
<p>Outpatient individual therapy (includes visits to monitor outpatient drug therapy).</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment, provided in a hospital outpatient setting or by a community mental health center that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> <p>Note: Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.</p>	<p>\$15 Copayment each visit</p> <p>\$15 Copayment per partial hospitalization day</p>
<p>Outpatient group therapy.</p>	<p>50% of individual therapy Copayment</p>

† Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Outpatient rehabilitation services†</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs)</p>	\$15 Copayment each visit
<p>Outpatient substance abuse services†</p> <p>We provide treatment and counseling services to diagnose and treat substance abuse (including individual and group therapy visits).</p>	
<p>Outpatient individual therapy</p>	<p>\$15 Copayment each visit</p> <p>\$15 Copayment per partial hospitalization day</p>
<p>Outpatient group therapy</p>	<p>50% of individual therapy Copayment</p>
<p>Outpatient surgery†, including services provided at hospital outpatient facilities and ambulatory surgical centers</p>	
<p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p>	\$150 Copayment each surgery
<p>Prescription drugs</p>	
<p>Deductible for Outpatient prescription drugs</p>	Not Applicable
<p>Initial Coverage Stage</p> <ul style="list-style-type: none"> • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Total Drug Costs 	<p>\$15 Generic/\$40 Brand name/\$40 Specialty/No Charge injectable Part D vaccines</p> <p>Up to \$3,750</p>
<p>Coverage Gap Stage</p> <ul style="list-style-type: none"> • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Out-of-Pocket Costs 	<p>\$15 Generic/\$40 Brand name/\$40 Specialty/No Charge injectable Part D vaccines</p> <p>Up to \$5,000</p>
<ul style="list-style-type: none"> • Prescribed supplies and accessories. 	No Charge
<p>Infertility drugs.</p>	Not Covered
<p>Sexual dysfunction drugs.</p>	Not Covered
	<u>Supply Limit</u>
<p>Day supply limit.</p>	30 days
<p>Mail-order supply limit.</p>	90 days @ 2 Copayments


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
Physician/practitioner services, including doctor's office visits	
<p>“Providers” include, but are not limited to, physicians, physician assistants and nurse practitioners.</p> <p>Covered services include:</p> <p>Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location.</p>	
Primary care visits	\$15 Copayment each visit
Specialty care visits (doctor or nurse visit).	\$30 Copayment each visit
Second opinion by another network provider prior to surgery.	Your primary care office visit copayment or specialty care office visit copayment, as applicable.
Outpatient surgery services †	\$150 Copayment each surgery
Consultations with clinical pharmacists	\$15 Copayment each visit
<p>Interactive video visits for professional services when care can be provided in this format as determined by a plan provider.</p> <p>Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a plan provider.</p>	<p>\$15 Copayment each visit or \$30 Copayment each visit copayment dependent upon provider</p> <p>No charge or No charge copayment dependent upon provider</p>
Non-routine dental care † (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	See specialty care office visit and Outpatient surgery cost-sharing above.
Chemotherapy visits.	Your specialty care office visit copayment plus your copayment or coinsurance for office-administered drugs.
Allergy injections.	\$15 Copayment each visit Copayment may apply for allergy serum
Allergy evaluation and testing.	\$30 Copayment each visit
Group visits—Cooperative Health Care Clinic (CHCC), Drop in Group Medical Appointment (DIGMA) and group mental health and substance abuse treatments.	Your primary care office visit copayment or \$10 copayment each visit, whichever is less.


† Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
Podiatry services	
<p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. 	See primary care office visit, specialty care office visit, and †Outpatient surgery cost-sharing above.
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following – once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam. • Prostate Specific Antigen (PSA) test. 	<p>There is no coinsurance, copayment or deductible for an annual digital rectal exam or PSA test.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive care you receive during or subsequent to the visit.</p>
<p>Prosthetic devices and related supplies †</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision care” later in this section for more detail.</p>	
Prosthetics	No Charge
Internally implanted prosthetic devices.	(See Hospital Inpatient Care and Outpatient Care for applicable cost-sharing)
Enteral and parenteral nutrition therapy covered under Medicare.	No Charge
Prosthetic arm or leg.	No Charge
Orthotic devices and related supplies.	No Charge
Oxygen	No Charge
<p>Pulmonary rehabilitation services. †</p> <p>Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	\$5 Copayment each visit


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p>Screening for lung cancer with low dose computed tomography (LDCT)†</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <ul style="list-style-type: none"> • Eligible members are people aged 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. • For LDCT lung cancer screenings after the initial LDCT screening, the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. 	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurances, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
<p>Services to treat kidney disease and conditions</p>	
<p>Covered services include:</p> <p>Kidney disease education services to teach kidney care and help members make informed decisions about their care.</p>	<p>\$15 Copayment each visit or \$30 Copayment each visit copayment dependent upon provider</p>
<ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply). <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section “Medicare Part B prescription drugs”.</p>	<p>No Charge</p>


† Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Skilled nursing facility (SNF) care† (For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines when prescribed by a network physician. No prior hospital stay is required.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body such as blood clotting factors.) • Blood – including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). <p>A SNF where your spouse is living at the time you leave the hospital.</p>	<p>No Charge</p> <p>Up to 100 days per benefit period</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven’t been an inpatient at any hospital or skilled nursing facility (SNF) for 60 calendar days in a row.</p> <p>Note: If a benefit period begins in 2017 for you and does not end until sometime in 2018, the 2017 cost-sharing will continue until the benefit period ends.</p>


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>
Urgently needed services	
<p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Urgently needed services received in a network urgent care department (or facility) and covered out-of-network urgent care when you are temporarily outside our service area.</p> <ul style="list-style-type: none"> • Inside our service area: You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • Outside our service area: You have worldwide urgent care coverage when you travel, if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. 	<p>\$30 Copayment each visit</p>
Vision care	
<p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people with diabetes, screening for diabetic retinopathy is covered once per year. 	


†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p>Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan covers the following exams: Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses.</p>	
<p>Eye exams performed by an optometrist</p>	<p>\$15 Copayment each visit</p>
<p>Eye exams performed by an ophthalmologist.</p>	<p>\$30 Copayment each visit</p>
<p> For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older:</p> <p>Glaucoma screening once per year.</p>	<p>No charge, unless member receives the screening in conjunction with other services, such as a routine eye exam, then member will be charged the applicable copayment.</p>
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Following Medicare-covered cataract surgery, the member may use their eyewear benefit (if purchased by your group) as described below to pay for upgrades to the Medicare covered eye wear benefit. The Medicare eyewear benefit following cataract surgery is covered per Medicare guidelines. 	<p>No charge, unless the cost exceeds the allowed Medicare fee schedule.</p>
<ul style="list-style-type: none"> • If purchased by your group, lenses, frames, medically necessary contact lenses, or cosmetic contact lenses every two years, purchased at a network optical facility. Any part of the eyewear benefit that is not exhausted at the first point of sale may not be used at a later date. This means that any benefit dollars remaining after the first point of sale are forfeited and cannot be applied to copayments for eye exams or contact lens professional fitting fees. • Eyeglasses and contact lenses must be prescribed by an optometrist or ophthalmologist and purchased at a network optical facility. • See exclusions for eye surgery to correct refractive defects and for cosmetic contact lenses that are not medically necessary later in this section. 	<p>\$200 Credit every 24 months See Additional Provisions *</p>

†Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these covered services
<p> “Welcome to Medicare” preventive visit</p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p> <p>The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.</p>

† Your provider must obtain prior authorization from our plan.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

2018 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

CHAPTER 1. Getting started as a member..... 3

Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, the Part D late enrollment penalty, your plan membership card, and keeping your membership record up-to-date.

CHAPTER 2. Important phone numbers and resources 22

Tells you how to get in touch with our plan (Senior Advantage) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

CHAPTER 3. Using our plan's coverage for your medical services 36

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in our plan's network and how to get care when you have an emergency.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay) 50

Gives the details about which types of medical care are covered and *not* covered for you as a member of our plan. Explains how much you will pay as your share of the cost of your covered medical care.

CHAPTER 5. Using our plan's coverage for your Part D prescription drugs..... 62

Explains rules you need to follow when you get your Part D drugs.
Tells how to use our **Kaiser Permanente 2018 Comprehensive Formulary** to find out which drugs are covered. Tells which kinds of drugs are *not* covered.
Explains several kinds of restrictions that apply to coverage for certain drugs.
Explains where to get your prescriptions filled. Tells about our plan's programs for drug safety and managing medications.

CHAPTER 6. What you pay for your Part D prescription drugs 81

Tells about the three stages of drug coverage (Initial Coverage Stage, Coverage Gap Stage, and Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the six cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier. Tells about the late enrollment penalty.

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs 97

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.

CHAPTER 8. Your rights and responsibilities 104

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints) 115

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

CHAPTER 10. Ending your membership in our plan..... 165

Explains when and how you can end your membership in our plan. Explains situations in which our plan is required to end your membership.

CHAPTER 11. Legal notices 171

Includes notices about governing law and about nondiscrimination.

CHAPTER 12. Definitions of important words 177

Explains key terms used in this booklet.

CHAPTER 1. Getting started as a member

SECTION 1. Introduction	5
Section 1.1 You are enrolled in Senior Advantage, which is a Medicare HMO.....	5
Section 1.2 What is the Evidence of Coverage booklet about?	5
Section 1.3 Legal information about the Evidence of Coverage.....	5
SECTION 2. What makes you eligible to be a plan member?	6
Section 2.1 Your eligibility requirements	6
Section 2.2 What are Medicare Part A and Medicare Part B?	6
Section 2.3 Here is our plan service area for Senior Advantage.....	7
Section 2.4 U.S. citizen or lawful presence.....	7
Section 2.5 Group eligibility requirements	8
Section 2.5 When you can enroll and when coverage begins	9
SECTION 3. What other materials will you get from us?	11
Section 3.1 Your plan membership card—use it to get all covered care and prescription drugs	11
Section 3.2 The Provider Directory : Your guide to all providers in our network.....	11
Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network	12
Section 3.4 Our plan's list of covered drugs (formulary)	12
Section 3.5 The Part D Explanation of Benefits (the "Part D <i>EOB</i> "): Reports with a summary of payments made for your Part D prescription drugs	13
SECTION 4. Your monthly premium for our plan	13
Section 4.1 How much is your plan premium?	13
SECTION 5. Do you have to pay the Part D “late enrollment penalty”?	14
Section 5.1 What is the Part D “late enrollment penalty”?	14
Section 5.2 How much is the Part D late enrollment penalty?.....	14
Section 5.3 In some situations, you can enroll late and not have to pay the penalty	15
Section 5.4 What can you do if you disagree with your Part D late enrollment penalty?	16
SECTION 6. Do you have to pay an extra Part D amount because of your income?	16
Section 6.1 Who pays an extra Part D amount because of income?	16
Section 6.2 How much is the extra Part D amount?.....	16

Section 6.3 What can you do if you disagree about paying an extra Part D amount?	17
Section 6.4 What happens if you do not pay the extra Part D amount?.....	17
SECTION 7. More information about your monthly premium.....	18
Section 7.1 Paying your plan premium	18
Section 7.2 Can we change your monthly plan premium during the year?	19
SECTION 8. Please keep your plan membership record up-to-date	19
Section 8.1 How to help make sure that we have accurate information about you	19
SECTION 9. We protect the privacy of your personal health information.....	20
Section 9.1 We make sure that your health information is protected.....	20
SECTION 10. How other insurance works with our plan	20
Section 10.1 Which plan pays first when you have other insurance?	20

SECTION 1. Introduction

Section 1.1 You are enrolled in Senior Advantage, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Kaiser Permanente Senior Advantage.

There are different types of Medicare health plans. Senior Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). approved by Medicare and run by a private company.

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of our plan.

If you are not certain which plan you are enrolled, please call Member Services or your group's benefit administrator.

This plan is offered by Kaiser Foundation Health Plan of Colorado (Health Plan) and it includes Medicare part D prescription drug coverage. When this **Evidence of Coverage** says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of our plan.

It is important for you to learn what our plan's rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

If you are confused or concerned or just have a question, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment form, our **Kaiser Permanente 2018 Comprehensive Formulary**, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

If your group renews on January 1st, the **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2018, and December 31, 2018,

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

unless amended. If your group's agreement renews at a later date in 2018, the term of this **Evidence of Coverage** is during that contract period, unless amended. Your group can tell you the term of this **Evidence of Coverage** and whether this **Evidence of Coverage** is still in effect, and give you a current one if this **Evidence of Coverage** has been amended.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018. In addition, your group can make changes to the plans and benefits it offers at any time.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we continue to offer our plan and Medicare renews its approval of our plan.

SECTION 2. What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (or Medicare Part B) (Section 2.2 below tells you about Medicare Part A and Medicare Part B).
- *-and-* you live in our geographic service area (Section 2.3 below describes our service area).
- *-and-* you are a United States citizen or are lawfully present in the United States.
- *-and-* you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is our plan service area for Senior Advantage

Although Medicare is a federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Colorado: **Boulder, Broomfield, Denver, and Gilpin**. Also, our service area includes these parts of counties in Colorado, **in the following ZIP codes only**:

- **Adams County:** 80002, 80003, 80010, 80011, 80019, 80020, 80022, 80023, 80024, 80030, 80031, 80035, 80036, 80037, 80040, 80042, 80045, 80102, 80137, 80212, 80216, 80221, 80229, 80233, 80234, 80241, 80247, 80249, 80260, 80601, 80602, 80603, 80614, 80640, 80642, and 80643.
- **Arapahoe County:** 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80041, 80044, 80046, 80047, 80102, 80110, 80111, 80112, 80113, 80120, 80121, 80122, 80123, 80128, 80129, 80137, 80150, 80151, 80154, 80155, 80160, 80161, 80165, 80166, 80222, 80231, 80236, 80246, and 80247.
- **Clear Creek County:** 80439 and 80452.
- **Douglas County:** 80104, 80108, 80109, 80112, 80116, 80124, 80125, 80126, 80129, 80130, 80131, 80134, 80135, 80138, and 80163.
- **Elbert County:** 80102, 80107, 80117, 80134, and 80138.
- **Jefferson County:** 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80020, 80021, 80031, 80033, 80034, 80123, 80127, 80128, 80162, 80212, 80214, 80215, 80225, 80226, 80227, 80228, 80232, 80235, 80401, 80402, 80403, 80419, 80425, 80433, 80437, 80439, 80453, 80454, 80457, 80465, and 80470.
- **Park County:** 80421 and 80470.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a special enrollment period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important to notify your group's benefits administrator and that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

Section 2.5 Group eligibility requirements

You must meet your group's eligibility requirements that we have approved. Your group is required to inform subscribers of its eligibility requirements, such as dependent eligibility requirements (for example, your spouse).

Please note that your group might not allow enrollment to some persons who meet the requirements described under "Additional eligibility requirements" below.

Additional eligibility requirements

Subscriber. You may be eligible to enroll as a subscriber under this **Evidence of Coverage** 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.

If you are a subscriber under this Evidence of Coverage or a subscriber enrolled in a non-Medicare plan offered by your group, the following persons may be eligible to enroll as your dependents under this Evidence of Coverage if they meet all the other requirements described in this section 2.5:

- Your spouse. (Spouse includes a partner in a valid civil union under state law.)
- Your or your Spouse's children (including adopted children, children placed with you for adoption, and foster children) who are under the dependent limiting age. Check with your group to determine the age limit for dependents.
- Other dependent persons who meet all of the following requirements:
 - ◆ they are under the dependent limiting age as determined by your group
 - ◆ you or your spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
- Your or your spouse's unmarried children of any age 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:
 - ◆ they are dependent on you or your spouse; and
 - ◆ you give us proof of the dependent's disability and dependency annually if we request it.
- Subscriber's designated beneficiaries as defined 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 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 the non-Medicare plan offered by your group. 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.

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this Evidence of Coverage, you may be able to enroll them as your dependents under a non-Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

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

Section 2.5 When you can enroll and when coverage begins

Your group is required to inform you when you are eligible to enroll and what your effective date of coverage is under this **Evidence of Coverage**. If you are eligible to enroll as described in this section, enrollment is permitted and membership begins at the beginning (12 a.m.) of the effective date of coverage, except that:

- Your group may have additional requirements that we have approved, which allow enrollment in other situations.
- The effective date of your Senior Advantage coverage under this **Evidence of Coverage** must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this section.

If you are a subscriber under this **Evidence of Coverage** and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this **Evidence of Coverage**, you may be able to enroll them as your dependents under a non-Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a dependent under this **Evidence of Coverage** but the subscriber in your family is enrolled under a non-Medicare plan offered by your group, the subscriber must follow the rules applicable to subscribers who are enrolling dependents in this Section 2.5.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage enrollment form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this **Evidence of Coverage**.

If CMS confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If CMS tell us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New subscribers

When your group informs you that you are eligible to enroll as a subscriber, you may enroll yourself and any eligible dependent by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group within 31 days after you become eligible, or as otherwise specified by your group.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new subscribers and their eligible family dependents is determined by your group, subject to confirmation by CMS.

Employees 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 Due to Loss of Other Coverage" below.

Adding new dependents to an existing account

To enroll a dependent who first becomes eligible to enroll after you became a subscriber (such as a new spouse, a newborn child, or a newly adopted child), you must submit a Health Plan-approved enrollment form and a Senior Advantage enrollment form to your group within 31 days after the dependent first becomes eligible, or as otherwise specified by your group.

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 Due to Loss of Other Coverage" below.

Effective date of Senior Advantage coverage. The effective date of coverage for newly acquired dependents is determined by your group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group 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 and a Senior Advantage enrollment form for each person to your group during your group's open enrollment period. Your group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by CMS.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless you become eligible as described in this "Special enrollment" section.

Special enrollment events

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 and a Senior Advantage enrollment form for each person to your group within 31 days after the enrolling persons lose other coverage, if:

The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason); and the loss of the other coverage is due to one of the following: For a comprehensive list of qualifying events for special enrollment see your Group's administrator to obtain a copy of your Group's **Evidence of Coverage**.

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 and a Senior Advantage enrollment form for each person to your group during your group's open enrollment period. Your group will let you know when the open enrollment period begins and ends and the membership effective date, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card—use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Senior Advantage membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Section 3.2 The Provider Directory: Your guide to all providers in our network

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers is available on our website at kp.org/directory.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and in some cases in which our plan authorizes use of out-of-network providers. See Chapter 3, "Using our plan's coverage for your medical services," for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can view or download the **Provider Directory** at kp.org/directory. Both Member Services and our website can give you the most up-to-date information about our network providers.

Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the **Pharmacy Directory** to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated **Pharmacy Directory** is located on our website at kp.org/directory. You may also call Member Services for updated provider information or to ask us to mail you a **Pharmacy Directory**. Please review the 2018 **Pharmacy Directory** to see which pharmacies are in our network.

If you don't have the **Pharmacy Directory**, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at kp.org/directory.

Section 3.4 Our plan's list of covered drugs (formulary)

Our plan has a **Kaiser Permanente 2018 Comprehensive Formulary**. We call it the "Drug List" for short. It tells you which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan with the help of a team of

doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

To get the most complete and current information about which drugs are covered, you can visit our website (kp.org/seniormedrx) or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.5 The Part D Explanation of Benefits (the "Part D EOB"): Report with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the **Part D Explanation of Benefits** (or the "**Part D EOB**").

The **Part D EOB** tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 ("What you pay for your Part D prescription drugs") gives you more information about the **Part D EOB** and how it can help you keep track of your drug coverage.

A **Part D EOB** summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet). You can also choose to get your **Part D EOB** online instead of by mail. Please visit kp.org/goinggreen and sign on to learn more about choosing to view your **Part D EOB** securely online.

SECTION 4. Your monthly premium for our plan

Section 4.1 How much is your plan premium?

Plan premiums

Your group is responsible for paying premiums. If you are responsible for any contribution to the premiums, your group will tell you the amount and how to pay your group.

SECTION 5. Do you have to pay the Part D “late enrollment penalty”?

Section 5.1 What is the Part D “late enrollment penalty”?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The amount of the penalty depends upon how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

If you are required to pay a Part D late enrollment penalty, your group will inform you the amount that you will be required to pay your group.

If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2018, this average premium amount is \$35.02.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times \$35.02, which equals \$4.90. This rounds to \$4.90. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, the penalty may change each year because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." **Please note:**
 - ◆ Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later. Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
 - ◆ The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
 - ◆ For additional information about creditable coverage, please look in your **Medicare & You** 2018 handbook or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree with your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6. Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, **you must pay an extra amount directly to the government** for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2017 was:	If you were married but filed a separate tax return and your income in 2017 was:	If you filed a joint tax return and your income in 2017 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$13.00
Greater than \$107,000 and less than or equal to \$133,500		Greater than \$214,000 and less than or equal to \$267,000	\$33.60
Greater than \$133,500 and less than or equal to \$160,000		Greater than \$267,000 and less than or equal to \$320,000	\$54.20
Greater than \$160,000	Greater than \$85,000	Greater than \$320,000	\$74.80

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at **1-800-772-1213 (TTY 1-800-325-0778)**.

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7. More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 of this chapter, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A and most plan members pay a premium for Medicare Part B. You must continue paying your Medicare premiums to remain a member of our plan.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than \$85,000 for an individual (or married individuals filing separately) or greater than \$170,000 for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from our plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Section 6 of this chapter. You can also visit <https://www.medicare.gov> on the Web or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or you may call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

Your copy of **Medicare & You** 2018 gives you information about Medicare premiums in the section called "2018 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You** 2018 from the Medicare website (<https://www.medicare.gov>) or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 7.1 Paying your plan premium

Your group is responsible for paying premiums. If you are responsible for any contribution to the premiums, your group will tell you the amount and how to pay your group.

Section 7.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for our plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8. Please keep your plan membership record up-to-date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 9. We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4, of this booklet.

SECTION 10. How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends upon your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - ♦ If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.

- ◆ If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance).
- Liability (including automobile insurance).
- Black lung benefits.
- Workers' compensation.

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2. Important phone numbers and resources

SECTION 1. Kaiser Permanente Senior Advantage contacts (how to contact us, including how to reach Member Services at our plan) **23**

SECTION 2. Medicare (how to get help and information directly from the federal Medicare program)..... **26**

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)..... **28**

SECTION 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare) **28**

SECTION 5. Social Security..... **29**

SECTION 6. Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)..... **30**

SECTION 7. Information about programs to help people pay for their prescription drugs **31**

SECTION 8. How to contact the Railroad Retirement Board **34**

SECTION 9. Do you have "group insurance" or other health insurance from an employer?..... **35**

SECTION 1. Kaiser Permanente Senior Advantage contacts

(how to contact us, including how to reach Member Services at our plan)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Senior Advantage Member Services. We will be happy to help you.

Method	Member Services – contact information
CALL	1-800-476-2167 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	303-214-6489
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	kp.org

How to contact us when you are asking for a coverage decision or making a complaint about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section about making an appeal.) For more information about asking for coverage decisions or making complaints about your medical care, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Method	Coverage decisions or complaints about medical care – contact information
CALL	1-800-476-2167 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	1-866-466-4042
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
MEDICARE WEBSITE	You can submit a <u>complaint</u> about our plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section below about making an appeal.)

For more information about asking for coverage decisions or making complaints about your Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

Method	Coverage decisions or complaints about Part D prescription drugs – contact information
CALL	1- 800-476-2167 Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.

TTY	711 Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.
FAX	1-866-455-1053
WRITE	Kaiser Foundation Health Plan of Colorado Pharmacy Benefits and Compliance 1975 Research Pkwy, Suite 250 Colorado Springs, CO 80920
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are making an appeal about your medical care or Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information about making an appeal about your medical care or Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

Method	Appeals for medical care or Part D prescription drugs – contact information
CALL	1-888-370-9858 Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.
TTY	711 Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.
FAX	1-866-466-4042
WRITE	Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

Method	Payment requests – contact information
CALL	1-800-476-2167 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Foundation Health Plan of Colorado Claims Department P.O. Box 373150 Denver, CO 80237-3150
WEBSITE	kp.org

SECTION 2. Medicare (how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our plan.

Method	Medicare – contact information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048

Method	Medicare – contact information
	<p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>https://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools:</p> <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information.• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Colorado, the SHIP is called Colorado State Health Insurance Assistance Program ("Colorado SHIP").

Colorado SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Colorado SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Colorado SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Colorado State Health Insurance Assistance Program – contact information
CALL	1-888-696-7213
WRITE	SHIP, Colorado Division of Insurance 1560 Broadway St., Ste. 850 Denver, CO 80202
WEBSITE	https://www.colorado.gov/pacific/dora/senior-healthcare-medicare

SECTION 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Colorado, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Colorado’s Quality Improvement Organization) – contact information
CALL	1-844-430-9504 Calls to this number are free. Monday to Friday, 9 a.m. to 5 p.m. Weekends and holidays, 11 a.m. to 3 p.m.
TTY	1-855-843-4776 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 Attention: Beneficiary Complaints
WEBSITE	https://www.keproqio.com

SECTION 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – contact information
CALL	1-800-772-1213

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Method	Social Security – contact information
	Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6. Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Health First Colorado (Medicaid).

Method	Health First Colorado (Colorado's Medicaid program) – contact information
CALL	1-800-221-3943 Calls to this number are free. Monday to Friday, 7:30 a.m. to 5:15 p.m.
TTY	711

Method	Health First Colorado (Colorado's Medicaid program) – contact information
WRITE	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203
WEBSITE	https://www.healthfirstcolorado.com www.healthfirstcolorado.com

SECTION 7. Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213**, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- Your state Medicaid office (applications) (see Section 6 in this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for "Extra Help." The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:
California Service Center
Attn: Best Available Evidence
P.O. Box 232407
San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**.
- Take it to a network pharmacy.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand-name drugs, the 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 35% of the negotiated price and a portion of the dispensing fee for brand-name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your **Part D Explanation of Benefits (Part D EOB)** will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap. The amount paid by the plan (15%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, we pay 56% of the price for generic drugs and you pay the remaining 44% of the price. For generic drugs, the amount paid by our plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6, for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 50% discount on covered brand-name drugs. Also, the plan pays 15% of the costs of brand-name drugs in the coverage gap. The 50% discount and the 15% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through **Bridging the Gap Colorado**. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call **Bridging the Gap Colorado** at **303-692-2716**.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **Bridging the Gap Colorado** at **303-692-2716**.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Part D Explanation of Benefits (Part D EOB)* notice. If the discount doesn't appear on your *Part D EOB*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this chapter) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

In Colorado, the name of the State Pharmaceutical Assistance Program is Bridging the Gap Colorado.

Method	Bridging the Gap Colorado- contact information
CALL	303-692-2716 Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Bridging the Gap Colorado C/O Colorado ADAP A3-3800 4300 Cherry Creek Drive South Denver, Colorado 80246-1530
WEBSITE	https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap

SECTION 8. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – contact information
CALL	1-877-772-5772 Calls to this number are free. Available 9 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY **1-312-751-4701**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are *not* free.

WEBSITE <https://www.secure.rrb.gov>

SECTION 9. Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this booklet. You may also call **1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048)** with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3. Using our plan's coverage for your medical services

SECTION 1. Things to know about getting your medical care covered as a member of our plan	37
Section 1.1 What are "network providers" and "covered services"?	37
Section 1.2 Basic rules for getting your medical care covered by our plan	37
SECTION 2. Use providers in our network to get your medical care	38
Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care	38
Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?	39
Section 2.3 How to get care from specialists and other network providers	40
Section 2.4 How to get care from out-of-network providers	42
SECTION 3. How to get covered services when you have an emergency or urgent need for care or during a disaster	42
Section 3.1 Getting care if you have a medical emergency	42
Section 3.2 Getting care when you have an urgent need for services	44
Section 3.3 Getting care during a disaster	44
SECTION 4. What if you are billed directly for the full cost of your covered services?	45
Section 4.1 You can ask us to pay our share of the cost for covered services	45
Section 4.2 If services are not covered by our plan, you must pay the full cost	45
SECTION 5. How are your medical services covered when you are in a "clinical research study"?	45
Section 5.1 What is a "clinical research study"?	45
Section 5.2 When you participate in a clinical research study, who pays for what?	46
SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"	47
Section 6.1 What is a religious nonmedical health care institution?	47
Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?	47
SECTION 7. Rules for ownership of durable medical equipment	48
Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?	48

SECTION 1. Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. It gives you definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by our plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the Medical Benefits Chart found at the front of this **EOC**.

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart found at the front of this **EOC**.

Section 1.2 Basic rules for getting your medical care covered by our plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

We will generally cover your medical care as long as:

- **The care you receive is included in our plan's Medical Benefits Chart** (found at the front of this **EOC**).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP)** who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - ◆ In most situations, your network PCP must give you approval in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).
 - ◆ Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
 - ◆ We cover emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - ◆ If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider if we authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.3 in this chapter.
 - ◆ We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.

SECTION 2. Use providers in our network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

As a member of our plan, you must choose a network provider to be your primary care provider (PCP). Your PCP is a health care professional who meets state requirements and is trained to give you primary medical care.

Your PCP will provide most of your care and may help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other network providers about your care and how it is going.

There are a few types of covered services you can get on your own without contacting your PCP first (see Section 2.2 in this chapter).

In some cases, your PCP will also need to get prior authorization (prior approval) from us. The services that require prior authorization from us are discussed in Section 2.3 of this chapter.

How do you choose your PCP?

You may choose a primary care provider from any of our available plan physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. When you make a selection, it is effective immediately. To learn how to choose a primary care provider, please call our Personal Physician Selection Services at **1-855-208-7221 (TTY 711)**, weekdays 7 a.m. to 5:30 p.m. You can also make your selection at **kp.org**.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our network of providers and you would have to find a new PCP. To change your PCP, call our Personal Physician Selection Team at **1-855-208-7221** or **711 (TTY)**, weekdays 7 a.m. to 5:30 p.m., or make your selection at **kp.org**.

When you call, be sure to tell our Personal Physician Selection Team if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Our Personal Physician Selection Team will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. When you make a new selection, the change is effective immediately.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (for example, when you are temporarily outside of our service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.) Phone numbers for Member Services are printed on the back cover of this booklet.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area. Please call Member Services or our away from home travel line at **1-951-268-3900** (24 hours a day, 7 days a week except holidays), **TTY 711**, for more information about getting care when visiting another Kaiser Permanente region's service area including coverage information

and facility locations in the District of Columbia and parts of California, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

- Consultation (routine office) visits to specialty-care departments within our plan, with the exception of the anesthesia clinical pain department.
- Second opinions from another network provider, except for certain specialty care.
- Mental health care or substance abuse services, as long as you get them from a network provider.
- Preventive care except abdominal aortic aneurysm and bone density screenings, as long as you get them from a network provider.
- Podiatry services as long as you get them from a network provider.
- Routine eye exams and hearing exams, as long as you get them from a network provider.
- Covered routine care from any Colorado Permanente Medical Group (CPMG) physician at any Kaiser Permanente medical office in our Southern Colorado or Northern Colorado service areas. Note: You cannot get routine care from affiliated network providers in the Southern Colorado or Northern Colorado service areas.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first, which are described in Section 2.2 of this chapter.

When your PCP prescribes specialized treatment, he or she will give you a referral to see a plan specialist or certain other network providers. However, for some types of specialty care referrals, your PCP may need to get approval in advance from our plan. If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

Prior authorization

For the services and items listed below and in Chapter 4, Sections 2.1 and 2.2, your PCP will need to get approval in advance from our plan (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

- For **certain specialty care**, your PCP will recommend to our plan that you be referred to a network specialist. The plan will authorize the services if it is determined that the covered

services are medically necessary. Referrals to such specialist will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network physician what services have been authorized. If the specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your PCP. You must have an authorized referral for ongoing treatment from a plan specialist except as described in Section 2.2. If you don't have a referral (approval in advance) before you get certain ongoing services, you may have to pay for these services yourself.

- If your PCP decides that you require **covered services not available from network providers**, he or she will recommend to our plan that you be referred to an out-of-network provider inside or outside our service area. The plan will authorize the services if it is determined that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your PCP what services have been authorized. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your PCP.
- If your network physician makes a written referral for **bariatric surgery**, the service will be evaluated for medical necessity by our bariatric surgeon and the Metabolic Surgery and Weight Management Department.
- After we are notified that you need **post-stabilization care** from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- If your specialist makes a written referral for a **transplant**, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are medically necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, the Medical Group will designate a specialist within the group to review and approve your transplant referral. Note: A plan physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us at **1-855-208-7221 (TTY 711)**, weekdays, 7 a.m. to 5:30 p.m., so we can assist you in finding a new provider and managing your care.

Section 2.4 How to get care from out-of-network providers

Care you receive from an out-of-network provider will not be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- Our plan authorizes a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.

SECTION 3. How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call **911** for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is listed on the back of your plan membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere inside or outside the United States. We cover ambulance services in situations where getting to the emergency room in any other way could endanger your health. You may get covered emergency medical care (including ambulance) when you need it anywhere in the world (claim forms required). For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. We will cover your follow-up post-stabilization care in accord with Medicare guidelines. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, we will cover your care as long as you reasonably thought your health was in serious danger.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- Or the additional care you get is considered "urgently needed services" and you follow the rules for getting these urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in our service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse or make an appointment, please refer to your **Provider Directory** for appointment and advice telephone numbers.

What if you are outside our service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, we will cover urgently needed services that you get from any provider. We cover urgently needed services anywhere in the world.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from us.

Please visit the following website—**kp.org**—for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, we will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5, for more information.

SECTION 4. What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs," for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

We cover all medical services that are medically necessary, listed in the Medical Benefits Chart (this chart is found at the front of this **EOC**), and obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted will not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs:

- We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
 - ◆ Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

- In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will not pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<https://www.medicare.gov>). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1 What is a religious nonmedical health care institution?

A religious nonmedical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious nonmedical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (nonmedical health care services). Medicare will only pay for nonmedical health care services provided by religious nonmedical health care institutions.

Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?

To get care from a religious nonmedical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

To be covered by our plan, the care you get from a religious nonmedical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - ◆ You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - ◆ – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in the Medical Benefits Chart found at the front of the EOC, Chapters 4 and 12.

SECTION 7. Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments.

You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

—

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1. Understanding your out-of-pocket costs for covered services 51

Section 1.1 Types of out-of-pocket costs you may pay for your covered services..... 51

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?..... 51

Section 1.3 Our plan does not allow providers to "balance bill" you 52

SECTION 2. Use the Medical Benefits Chart at the front of this EOC to find out what is covered for you and how much you will pay 53

Section 2.1 Your medical benefits and costs as a member of our plan..... 53

SECTION 3. What services are not covered by our plan? 54

Section 3.1 Services we do *not* cover (exclusions) 54

SECTION 1. Understanding your out-of-pocket costs for covered services

This chapter and the Medical Benefits Chart found at the front of this **EOC** focuses on your covered services and what you pay for your medical benefits. The Medical Benefits Chart lists your covered services and some limitations, and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapters 3, 11, and 12 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your copayments.)
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart located found at the front of this **EOC** tells you more about your coinsurance.)
- The "**deductible**" is the amount you must pay for medical services before our plan begins to pay its share for your covered medical services. (**Note:** Not all plans have a deductible.) Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance). The deductible does not apply to some services. (The Medical Benefits Chart found at the front of this **EOC** tells you if your plan has a deductible, the deductible amount, and which services are subject to the deductible.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Part A and Part B (see the Medical Benefits Chart located at the front of this **EOC**). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2018 is stated in the Medical Benefits Chart found at the front of this **EOC**. The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart found at the front of this **EOC**.

If you reach the maximum out-of-pocket amount stated in the Medical Benefits Chart found at the front of this **EOC**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that, after you meet any deductibles (if applicable to your plan), you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
 - ◆ If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
 - ◆ If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
 - ◆ If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, our plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

- ◆ If you believe a provider has “balance billed” you, call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2. Use the Medical Benefits Chart at the front of this EOC to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of our plan

The Medical Benefits Chart found at the front of this **EOC** lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only when the following coverage requirements are met:


- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart found at the front of this **EOC** with a footnote (†). In addition, see Section 2.2 in this chapter and Chapter 3, Section 2.3, for more information about prior authorizations, including other services that require prior authorization that are not listed in the Medical Benefits Chart found at the front of this **EOC**

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2018** handbook. View it online at <https://www.medicare.gov> or ask for a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the Medical Benefits Chart found at the front of this **EOC**.

SECTION 3. What services are not covered by our plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that we don't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception is we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3, in this booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart at the front of this **EOC** or in the chart below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		√ The exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Experimental medical and surgical procedures, equipment and medications <ul style="list-style-type: none"> • Experimental procedures and items are those items 		√ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community		(See Chapter 3, Section 5 for more information about clinical research studies.)
Private room in a hospital		√ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	√	
Full-time nursing care in your home	√	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care <ul style="list-style-type: none"> • Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing 	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Fees charged by your immediate relatives or members of your household	√	
Cosmetic surgery or procedures		√

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		<p>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</p> <p>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</p>
Routine dental care, such as cleanings, fillings, or dentures		<p style="text-align: center;">√</p> <p>Not covered unless your group has purchased coverage. Refer to the Medical Benefits Chart at the front of this EOC.</p>
Nonroutine dental care		<p style="text-align: center;">√</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
Routine chiropractic care		<p style="text-align: center;">√</p> <p>Manual manipulation of the spine to correct a subluxation is covered.</p> <p>In addition this exclusion does not apply if your employer purchased coverage for additional chiropractic care. Refer to the Medical Benefits Chart at the front of this EOC.</p>
Routine foot care		<p style="text-align: center;">√</p> <p>Some limited coverage provided according to Medicare guidelines, for example, if you have diabetes.</p>
Home-delivered meals	√	
Orthopedic shoes		<p style="text-align: center;">√</p> <p>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</p>

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		<p style="text-align: center;">√</p> <p>Orthopedic or therapeutic shoes for people with diabetic foot disease.</p>
Hearing aids		<p style="text-align: center;">√</p> <p>This exclusion does not apply if your group has purchased hearing aid coverage. Refer to the Medical Benefits Chart in the front of this EOC.</p> <p>Note: For all members, this hearing aid exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.</p>
Eyeglasses and contact lenses		<p style="text-align: center;">√</p> <p>One pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. No other eyewear is covered unless your employer purchased such coverage for eyewear. Refer to the Medical Benefits Chart at the front of this EOC.</p> <p>Eyewear benefits do not cover the following services or items:</p> <ul style="list-style-type: none"> • Industrial frames. • Lenses and sunglasses without refractive value, except that this exclusion does not apply to any of the following: <ul style="list-style-type: none"> ◆ A clear balance lens if only one eye needs correction. ◆ Tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa. • Replacement of lost, broken, or damaged lenses or frames.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		<ul style="list-style-type: none"> • Eyeglass or contact lens adornment, such as engraving, faceting, or jewelings. • Eyewear items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits.
Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids	√	
Reversal of sterilization procedures and non-prescription contraceptive supplies.	√	
Acupuncture		√ This exclusion does not apply if your employer has purchased coverage for acupuncture. Refer to the Medical Benefits Chart at the front of the EOC .
Naturopath services (uses natural or alternative treatments)	√	
Private duty nursing	√	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		√ Covered if medically necessary and covered under Original Medicare.
Services provided to veterans in Veterans Affairs (VA) facilities		√ When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		<p style="text-align: center;">√</p> We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Surgery that, in the judgment of a network physician specializing in reconstructive surgery, offers only a minimal improvement in appearance. Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance	√	
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)		<p style="text-align: center;">√</p> You may request and we may provide insertion of a presbyopia-correcting IOL or astigmatism-correcting IOL following cataract surgery in lieu of a conventional IOL. However, you must pay the difference between Plan Charges for a nonconventional IOL and associated services and Plan Charges for insertion of a conventional IOL following cataract surgery.
Directed blood donations	√	
Massage therapy		√

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Transportation by air, car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	√	
Licensed ambulance services without transport		√ Covered if the ambulance transports you or if covered by Medicare.
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		√ Covered if a network physician determines that the services are medically appropriate preventive care.
Services related to noncovered services or items		√ When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in		√ This exclusion applies to services provided anywhere, even outside the U.S. It does not apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
the U.S., but are not approved by the FDA		

CHAPTER 5. Using our plan's coverage for your Part D prescription drugs

SECTION 1. Introduction	64
Section 1.1 This chapter describes your coverage for Part D drugs.....	64
Section 1.2 Basic rules for our plan's Part D drug coverage.....	65
SECTION 2. Fill your prescription at a network pharmacy or through our mail-order service	65
Section 2.1 To have your prescription covered, use a network pharmacy.....	65
Section 2.2 Finding network pharmacies	66
Section 2.3 Using our mail-order services	66
Section 2.4 How can you get a long-term supply of drugs?	67
Section 2.5 When can you use a pharmacy that is not in our network?.....	68
SECTION 3. Your drugs need to be on our "Drug List"	69
Section 3.1 The "Drug List" tells which Part D drugs are covered.....	69
Section 3.2 There are six "cost-sharing" tiers" for drugs on our <i>Drug List</i>	69
Section 3.3 How can you find out if a specific drug is on our Drug List?.....	70
SECTION 4. There are restrictions on coverage for some drugs.....	70
Section 4.1 Why do some drugs have restrictions?.....	70
Section 4.2 What kinds of restrictions?.....	71
Section 4.3 Do any of these restrictions apply to your drugs?.....	71
SECTION 5. What if one of your drugs is not covered in the way you'd like it to be covered?	72
Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered	72
Section 5.2 What can you do if your drug is not on our Drug List or if the drug is restricted in some way?	72
Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?	74
SECTION 6. What if your coverage changes for one of your drugs?	75
Section 6.1 The Drug List can change during the year	75
Section 6.2 What happens if coverage changes for a drug you are taking?	75

SECTION 7. What types of drugs are not covered by our plan?	76
Section 7.1 Types of drugs we do not cover	76
SECTION 8. Show your plan membership card when you fill a prescription	77
Section 8.1 Show your membership card.....	77
Section 8.2 What if you don't have your membership card with you?.....	77
SECTION 9. Part D drug coverage in special situations	78
Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?	78
Section 9.2 What if you're a resident in a long-term care (LTC) facility?.....	78
Section 9.3 Special note about "creditable coverage"	79
Section 9.4 What if you're in Medicare-certified hospice?	79
SECTION 10. Programs on drug safety and managing medications	79
Section 10.1 Programs to help members use drugs safely	79
Section 10.2 Medication Therapy Management (MTM) program to help members manage their medications	80

SECTION 1. Introduction



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The Medical Benefits Chart found at the front of this **EOC** and the next chapter tell you what you pay for Part D drugs (Chapter 6, "What you pay for your Part D prescription drugs").

In addition to your coverage for Part D drugs, we also cover some drugs under our plan's medical benefits. Through our coverage of Medicare Part A benefits, we generally cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through our coverage of Medicare Part B benefits, we cover drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The Medical Benefits Chart found at the front of this **EOC** tells you about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. We only cover Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions, and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 in this chapter, "What if you're in Medicare-certified hospice." For information on hospice coverage, see the hospice section of the Medical Benefits Chart at the front of this **EOC**.

If your group has purchased enhanced Part D prescription drug coverage, we cover some drugs that are not covered by Medicare Part B and Part D in accord with our formulary for non-Part D

drugs. The Medical Benefits Chart at the front of this **EOC** tells you about your benefits and costs for these drugs.

The following sections discuss coverage of your drugs under our plan's Part D benefit rules. Section 9 in this chapter, "Part D drug coverage in special situations," includes more information about your Part D coverage and Original Medicare.

Section 1.2 Basic rules for our plan's Part D drug coverage

Our plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, "Fill your prescriptions at a network pharmacy or through our mail-order service.")
- Your drug must be on our **Kaiser Permanente 2018 Comprehensive Formulary** (we call it the "Drug List" for short). (See Section 3, "Your drugs need to be on our Drug List.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2. Fill your prescription at a network pharmacy or through our mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at our network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on our plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (kp.org/directory), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in our network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at kp.org/directory.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. However, currently this is not applicable to our plan because there are no such pharmacies inside our service area.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.

Note: This scenario should happen rarely.

To locate a specialized pharmacy, look in your **Pharmacy Directory** or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using our mail-order services

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, the drugs provided through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List.

Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply.

To get information about filling your prescriptions by mail, call Member Services. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call our mail-order service at **303-326-6777** or toll free at **1-866-523-6059 (TTY 711)**, Monday through Friday, 8 a.m. to 6 p.m.
- Call the highlighted number listed on your prescription label and follow the prompts. Be sure to select the mail delivery option when prompted.
- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular mail-order service). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed, or see our *Drug List* for information about the drugs that can be mailed.

Usually a mail-order pharmacy order will get to you in no more than 10 days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network pharmacy listed in your **Pharmacy Directory** or at **kp.org/directory**. Please be aware that you will pay more if you get a 90-day supply from a network pharmacy instead of from our mail-order pharmacy.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 10 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. When you place your order, please provide your current contact information in case we need to reach you.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. Our plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition. You may order this supply through mail order (see Section 2.3 in this chapter) or you may go to a retail pharmacy.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

2. For certain kinds of drugs, you can use our plan's network mail-order services. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List. Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. **Note:** Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. Phone numbers for Member Services are printed on the back cover of this booklet. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, explains how to ask us to pay you back.)

SECTION 3. Your drugs need to be on our "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

Our plan has a **Kaiser Permanente 2018 Comprehensive Formulary**. In this **Evidence of Coverage**, we call it the "Drug List" for short.

The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Or supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

Our Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

What is not on our Drug List?

Our plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are six "cost-sharing" tiers" for drugs on our *Drug List*

Every drug on our plan's Drug List is in one of six cost-sharing tiers. Depending upon the plan your group has selected, cost-sharing may vary from one tier to the next. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs.
- Cost-sharing **Tier 2** for generic drugs.

- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs.
- Cost-sharing **Tier 5** for specialty-tier drugs.
- Cost-sharing **Tier 6** for injectable Part D vaccines.

To find out which cost-sharing tier your drug is in, look it up on our Drug List. The amount you pay for drugs in each cost-sharing tier is shown in the Medical Benefits Chart found at the front of this **EOC**.

Section 3.3 How can you find out if a specific drug is on our Drug List?

You have three ways to find out:

1. Check the most recent Drug List.
2. Visit our website (kp.org/seniormedrx). Our Drug List (**Kaiser Permanente 2018 Comprehensive Formulary**) on the website is always the most current.
3. Call Member Services to find out if a particular drug is on our plan's Drug List (**Kaiser Permanente 2018 Comprehensive Formulary**) or to ask for a copy of the list. Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 4. There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when we cover them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once on our Drug List (**Kaiser Permanente 2018 Comprehensive Formulary**). This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed

by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. In most cases, when a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version. We usually will not cover the brand-name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan.

Section 4.3 Do any of these restrictions apply to your drugs?

Our plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (kp.org/seniormedrx).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

SECTION 5. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by our plan have extra rules to restrict their use. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. Our plan puts each covered drug into one of six different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend upon what type of problem you have:

- If your drug is not on our Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on our Drug List or if the drug is restricted in some way?

If your drug is not on our Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask us to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, we can offer a temporary supply of a drug to you when your drug is not on our Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- ◆ The drug you have been taking is no longer on our plan's Drug List.
- ◆ Or the drug you have been taking is now restricted in some way (Section 4 in this chapter tells you about restrictions).

2. You must be in one of the situations described below:

- ◆ **For those members who are new or who were in our plan last year and aren't in a long-term care (LTC) facility:** We will cover a temporary supply of your drug during the first 90 days of your membership in our plan if you are new and during the first 90 days of the calendar year if you were in our plan last year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.
- ◆ **For those members who are new or who were in our plan last year and reside in a long-term care (LTC) facility:** We will cover a temporary supply of your drug during the first 90 days of your membership in our plan if you are new and during the first 90 days of the calendar year if you were in our plan last year. The total supply will be for a maximum of a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- ◆ **For those members who have been in our plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:** We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.
- ◆ As a current member of our plan, **if you have a covered inpatient stay in the hospital or in a skilled nursing facility**, the drugs you obtain during your stay will be covered under your medical benefit rather than your Medicare Part D prescription drug coverage. When you are discharged home or to a custodial level of care at a long-term care facility, many outpatient prescription drugs you obtain at a pharmacy will be covered under your Medicare Part D coverage. Since your drug coverage is different depending upon the setting where you obtain the drug, it is possible that a drug you were taking that was covered under your medical benefit might not be covered by Medicare Part D (for example, over-the-counter drugs or cough medicine). If this happens, you will have to pay full price for that drug unless you have other coverage (for example, employer group or union coverage).

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by our plan or ask us to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by our plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on our plan's Drug List. Or you can ask us to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

For drugs in Tiers 2-4, you and your provider can ask us to make an exception to the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our specialty tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6. What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, we might make changes to the Drug List. For example, we might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- Replace a brand-name drug with a generic drug.

In almost all cases, we must get approval from Medicare for changes we make to our Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, we will send you a notice to tell you. Normally, we will let you know at least 60 days ahead of time.

Once in a while, a drug is suddenly recalled because it's been found to be unsafe or for other reasons. If this happens, we will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in our plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happen to a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a brand-name drug you are taking is replaced by a new generic drug, we must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
 - ◆ During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - ◆ Or you and your provider can ask us to make an exception and continue to cover the brand-name drug for you. For information about how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
- Again, if a drug is suddenly recalled because it's been found to be unsafe or for other reasons, we will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - ◆ Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7. What types of drugs are not covered by our plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section; the only exception is if the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - ◆ Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology; or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Nonprescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra[®], Cialis[®], Levitra[®], and Caverject[®].
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8. Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill our plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call our plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1, for information about how to ask us for reimbursement.

SECTION 9. Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell you about the rules for getting drug coverage. The Medical Benefits Chart found at the front of this **EOC** gives you more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, "Ending your membership in our plan," tells you when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of our plan?

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of up to a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of our plan for more than 90 days and need a drug that is not on our Drug List or if our plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by our plan that might work just as well for you. Or you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do.

Section 9.3 Special note about "creditable coverage"

Each year your employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage, from your employer or retiree group plan, you can get a copy from your employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D. Chapter 6, "What you pay for your Part D prescription drugs," gives more information about drug coverage and what you pay.

SECTION 10. Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

CHAPTER 6. What you pay for your Part D prescription drugs

SECTION 1. Introduction	83
Section 1.1 Use this chapter together with other materials that explain your drug coverage.....	83
Section 1.2 Types of out-of-pocket costs you may pay for covered drugs	84
SECTION 2. What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug	84
Section 2.1 What are the drug payment stages for Senior Advantage members?.....	84
SECTION 3. We send you reports that explain payments for your drugs and which payment stage you are in	86
Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB").....	86
Section 3.2 Help us keep our information about your drug payments up-to-date	86
SECTION 4. During the Deductible Stage, if applicable, you pay the full cost of your drugs	87
Section 4.1 If your plan includes a deductible for your Part D drugs	87
SECTION 5. During the Initial Coverage Stage, we pay our share of your drug costs and you pay your share	88
Section 5.1 What you pay for a drug depends upon the drug and where you fill your prescription.....	88
Section 5.2 Your costs for a one-month supply of a drug.....	88
Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply	89
Section 5.4 Your costs for a long-term (up to a 90-day) supply of a drug.....	90
Section 5.5 You stay in the Initial Coverage Stage until you reach the next stage.....	90
SECTION 6. During the Coverage Gap Stage, if applicable, we provide some drug coverage.....	91
Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$5,000	91
Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs	91

SECTION 7. During the Catastrophic Coverage Stage, we pay most of the cost for your drugs.....	93
Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year	93
SECTION 8. What you pay for vaccinations covered by Part D depends upon how and where you get them	94
Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine.....	94
Section 8.2 You may want to call Member Services before you get a vaccination	95



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered under your group's plan.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- Our **Kaiser Permanente 2018 Comprehensive Formulary**. To keep things simple, we call this the "**Drug List**."
 - ◆ This Drug List tells you which drugs are covered for you.
 - ◆ It also tells you which of the six "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
 - ◆ If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at kp.org/seniormedrx. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet**. Chapter 5 gives you the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells you which types of prescription drugs are not covered by our plan.
- **Our plan's Pharmacy Directory**. In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The **Pharmacy Directory** has

a list of pharmacies in our plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The "deductible" is the amount you must pay for drugs before our plan begins to pay its share.
- "Copayment" means that you pay a fixed amount each time you fill a prescription.
- "Coinsurance" means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2. What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Senior Advantage members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends upon which of these stages you are in at the time you get a prescription filled or refilled. Stage 4 applies to everyone, but your group plan may not include a Deductible Stage (Stage 1) or a Coverage Gap Stage (Stage 3). Refer to the Medical Benefits Chart found at the front of this **EOC** to find out which stages apply to you. Keep in mind you are always responsible for our plan's monthly premium regardless of the drug payment stage.

Stage 1	Stage 2	Stage 3	Stage 4
<p>Yearly Deductible Stage</p> <p>See the Medical Benefits Chart at the front of the EOC to find out if this payment stage applies to you. (This stage does not apply to most members.)</p> <p>If your plan has a deductible, during this stage, you pay the full cost of your drugs. You stay in this stage until you have paid your deductible.</p> <p>(Details are in Section 4 of this chapter.)</p>	<p>Initial Coverage Stage</p> <p>If your plan has a deductible, you begin in this stage after you end the Deductible Stage (if your plan has a deductible).</p> <p>If your plan does not have a deductible, you begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, we pay our share of the cost of your drugs and you pay your share of the cost.</p> <p>If your plan has a Coverage Gap Stage, you stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total \$3,750.</p> <p>If your plan does not have a Coverage Gap Stage, you stay in this stage until your year-to-date "out-of-pocket costs" (your payments) total \$5,000.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>Coverage Gap Stage</p> <p>See the Medical Benefits Chart at the front of this EOC to find out if this stage applies to you (this stage does not apply to most members).</p> <p>If there is no coverage gap for your plan, this payment stage does not apply to you.</p> <p>If this stage applies to you, coverage during the gap stage varies depending on the plan your group has selected.</p> <p>For generic drugs, you pay either the copayment listed in Section 6 of this chapter, depending upon the plan in which you are enrolled, or 44% of the price, whichever is lower.</p> <p>For brand-name drugs, you pay 35% of the price (plus a portion of the dispensing fee).</p> <p>You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$5,000. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>Catastrophic Coverage Stage</p> <p>During this stage, we will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2018).</p> <p>(Details are in Section 7 of this chapter.)</p>

SECTION 3. We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs.**" This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the **Part D Explanation of Benefits** (it is sometimes called the "**Part D EOB**") when you have had one or more prescriptions filled through our plan during the previous month. It includes:

- **Information for that month.** This report gives you the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up-to-date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up-to-date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask us to pay our share of the cost. For instructions about how to do this, go to Chapter 7, Section 2, of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- ◆ When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- ◆ When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- ◆ Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a **Part D Explanation of Benefits** (a **Part D EOB**) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also choose to view your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4. During the Deductible Stage, if applicable, you pay the full cost of your drugs

See the Medical Benefits Chart found at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members).

Section 4.1 If your plan includes a deductible for your Part D drugs

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount. Please refer to the Medical Benefits Chart found at the front of this **EOC** for the deductible amount.

- ◆ Your "**full cost**" is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- ◆ The "**deductible**" is the amount you must pay for your Part D prescription drugs before our plan begins to pay its share.

Once you have paid the deductible amount shown in the Medical Benefits Chart found at the front of this **EOC**, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5. During the Initial Coverage Stage, we pay our share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends upon the drug and where you fill your prescription

During the Initial Coverage Stage, we pay our share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending upon the drug and where you fill your prescription.

Our plan has six cost-sharing tiers

Every drug on our plan's Drug List is in one of six cost-sharing tiers. Depending upon the plan your group has selected, cost-sharing may vary from one tier to the next. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs.
- Cost-sharing **Tier 2** for generic drugs.
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs.
- Cost-sharing **Tier 5** for specialty-tier drugs.
- Cost-sharing **Tier 6** for injectable Part D vaccines.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends upon whether you get the drug from:

- A retail pharmacy that is in our plan's network.
- A pharmacy that is not in our plan's network.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and our plan's **Pharmacy Directory**.

Section 5.2 Your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- "**Copayment**" means that you pay a fixed amount each time you fill a prescription.
- "**Coinsurance**" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the Medical Benefits Chart found at the front of this **EOC**, the amount of the copayment or coinsurance depends upon which cost-sharing tier your drug is in. **Please note:**

- If your covered drug costs less than the copayment amount listed in the Medical Benefits Chart found at the front of this **EOC**, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, for information about when we will cover a prescription filled at an out-of-network pharmacy.

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts and day supply limit in the Initial Coverage Stage.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
 - ◆ Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is \$30. This means that the amount you pay per day for your drug is \$1. If you receive a 7 days' supply of the drug, your payment will be \$1 per day multiplied by 7 days, for a total payment of \$7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 Your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts when you get a long-term (up to a 90-day) supply of a drug.

- **Please note:** If your covered drug costs less than the copayment amount listed in the Medical Benefits Chart found at the front of this **EOC**, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

Section 5.5 You stay in the Initial Coverage Stage until you reach the next stage

If your group plan does not include a Coverage Gap Stage, you stay in the Initial Coverage Stage until your total out-of-pocket costs reach **\$5,000**. When you reach an out-of-pocket limit of **\$5,000**, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. Most group plans do not include a Coverage Gap Stage.

If your group plan includes a Coverage Gap Stage, you stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$3,750 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - ◆ The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What our plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2018, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The **Part D Explanation of Benefits (Part D EOB)** that we send to you will help you keep track of how much you and our plan, as well as third parties have spent on your behalf during the year. Many people do not reach the **\$3,750** limit in a year.

We will let you know if you reach this **\$3,750** amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Refer to the Medical Benefits Chart found at the front of this **EOC** for the amount you will pay for drugs in the Coverage Gap Stage.

SECTION 6. During the Coverage Gap Stage, if applicable, we provide some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$5,000

The benefit coverage you receive during the Coverage Gap Stage will depend on the benefits your group selected. See the Medical Benefits Chart found at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members).

Brand-name drugs during the Coverage Gap Stage

When you are in the Coverage Gap Stage, **the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs** (Tiers 3–5). You pay 35% of the negotiated price and a portion of the dispensing fee for brand-name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap.

Generic drugs and vaccines during the Coverage Gap Stage

You also receive coverage of generic drugs and injectable Part D vaccines during the Coverage Gap Stage. You pay either the copayments listed in the Medical Benefits Chart found at the front of this **EOC** or 44% of the costs of generic drugs, whichever is lower, until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2018, that amount is **\$5,000**.

You continue paying the discounted price for brand-name drugs and no more than 51% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2018, that amount is **\$5,000**.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of **\$5,000**, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:

- ◆ The Deductible Stage (if this stage applies to you).
- ◆ The Initial Coverage Stage.
- ◆ The Coverage Gap Stage (if this stage applies to you).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount we pay for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **\$5,000** in out-of-pocket costs within the calendar year, you will move from either the Initial Coverage Stage (if this stage applies to you) or the Coverage Gap Stage (if this stage applies to you) to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not** allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group's premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet our plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare prescription drug plan.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments made by our plan for your brand or generic drugs while in the Coverage Gap, if this stage applies to you.

- Payments for your drugs that are made by group health plans, including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The **Part D Explanation of Benefits (Part D EOB)** report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells you about this report). When you reach a total of **\$5,000** in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells you what you can do to help make sure that our records of what you have spent are complete and up-to-date.

SECTION 7. During the Catastrophic Coverage Stage, we pay most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **\$5,000** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, we will pay most of the cost for your drugs.

You will pay **\$3.05** for covered generic drugs (includes drugs treated like generics). You will pay **\$8.10** for covered brand-name and specialty-tier drugs, and **\$0** for covered injectable Part D vaccines. We will pay the rest.

SECTION 8. What you pay for vaccinations covered by Part D depends upon how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

We provide coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart found at the front of this **EOC**.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.
- The second part of coverage is for the cost of giving you the vaccine. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends upon three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - ◆ Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the Medical Benefits Chart found at the front of this **EOC**.
 - ◆ Other vaccines are considered Part D drugs. You can find these vaccines listed in our **Kaiser Permanente 2018 Comprehensive Formulary**.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending upon the circumstances. For example:

- ◆ Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask us to pay you back for our share of the cost.
- ◆ Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine.

If your plan has a Deductible Stage, remember you are responsible for all of the costs associated with Part D vaccines (including their administration) during the Deductible Stage of your benefit.

Situation 1:

- You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to administer a vaccination.)
 - ◆ You will have to pay the pharmacy the amount of your copayment for the vaccine and the cost of giving you the vaccine.
 - ◆ Our plan will pay the remainder of the costs.

Situation 2:

- You get the Part D vaccination at your doctor's office.
 - ◆ When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
 - ◆ You can then ask us to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet ("Asking us to pay our share of a bill you have received for covered medical services or drugs").
 - ◆ You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).

Situation 3:

- You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.
 - ◆ You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
 - ◆ When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask us to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
 - ◆ You will be reimbursed the amount charged by the doctor for administering the vaccine.

IMPORTANT NOTE: Generally, when you receive a covered injectable Part D vaccine at a Kaiser Permanente network medical office or injection clinic, **there is no charge for the injectable vaccine.** We may send you a bill for the vaccine administration or office visit copayment, if applicable.

**Section 8.2 You may want to call Member Services
before you get a vaccination**

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you first call Member Services whenever you are planning to get a vaccination. Phone numbers for Member Services are printed on the back cover of this booklet.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

**CHAPTER 7. Asking us to pay our share of a bill you have received
for covered medical services or drugs**

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs 98

Section 1.1 If you pay our share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment..... 98

SECTION 2. How to ask us to pay you back or to pay a bill you have received 100

Section 2.1 How and where to send us your request for payment 100

SECTION 3. We will consider your request for payment and say yes or no 101

Section 3.1 We check to see whether we should cover the service or drug and how much we owe..... 101

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal 101

SECTION 4. Other situations in which you should save your receipts and send copies to us 102

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs..... 102

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

When you've received emergency or urgently needed medical care from a provider who is not in our network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - ◆ If the provider is owed anything, we will pay the provider directly.
 - ◆ If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

When a network provider sends you a bill you think you should not pay

Network providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we

don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

If you are retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5, to learn more.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

-
- For example, the drug may not be on our **Kaiser Permanente 2018 Comprehensive Formulary**; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
 - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

When you pay copayments under a drug manufacturer patient assistance program

If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage.

- Save your receipt and send a copy to us.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

SECTION 2. How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask for the form. Phone numbers for Member Services are printed on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

Kaiser Foundation Health Plan of Colorado
Claims Department
P.O. Box 373150
Denver, CO 80237-3150

You must submit your claim to us within 365 days of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3. We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the section in Chapter 9 that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.

- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4. Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage or Coverage Gap Stage (if your plan has one or both—refer to the Medical Benefits Chart found at the front of this **EOC**), you can buy your drug at a network pharmacy for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible or Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through our plan's benefits, we will not pay for any share of these drug costs. But sending

a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8. Your rights and responsibilities

SECTION 1. We must honor your rights as a member of our plan	105
Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or CD).....	105
Section 1.2 We must treat you with fairness and respect at all times	106
Section 1.3 We must ensure that you get timely access to your covered services and drugs	106
Section 1.4 We must protect the privacy of your personal health information.....	106
Section 1.5 We must give you information about our plan, our network of providers, and your covered services	107
Section 1.6 We must support your right to make decisions about your care	109
Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made	110
Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?	111
Section 1.9 How to get more information about your rights.....	111
Section 1.10 Information about new technology assessments	111
SECTION 2. You have some responsibilities as a member of our plan.....	112
Section 2.1 What are your responsibilities?	112

SECTION 1. We must honor your rights as a member of our plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or CD)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. This booklet is available in Spanish by calling Member Services (phone numbers are on the back cover of this booklet). We can also give you information in Braille, large print, or CD at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Member Services for additional information.

Sección 1.1 Debemos proporcionar la información de un modo adecuado para usted (en idiomas distintos al inglés, en Braille, en letra grande o en CD)

Para obtener información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de interpretación disponibles sin costo para responder las preguntas de los miembros discapacitados y que no hablan inglés. Este folleto está disponible en español o chino; llame a Servicio a los Miembros (los números de teléfono están en la contraportada de este folleto). Si la necesita, también podemos darle, sin costo, información en Braille, letra grande o CD. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener nuestra información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto) o comuníquese con nuestro Coordinador de Derechos Civiles.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, por favor llame para presentar una queja a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto). También puede presentar una queja en Medicare llamando al **1-800-MEDICARE (1-800-633-4227)** o directamente en la Oficina de Derechos Civiles. En esta Evidence of Coverage (**Evidencia de**

Cobertura) o en esta carta se incluye la información de contacto, o bien puede comunicarse con Servicio a los Miembros para obtener información adicional.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019 (TTY 1-800-537-7697)** or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist), a mental health services provider, and a provider for routine eye exams without a referral, as well as other providers described in Chapter 3, Section 2.2.

As a plan member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10, of this booklet tells you what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4, tells you what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in our plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- Your health information is shared with your Group only with your authorization or as otherwise permitted by law.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - ◆ For example, we are required to release health information to government agencies that are checking on quality of care.
 - ◆ Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish and in Braille, large print or CD.

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers, including our network pharmacies.**
 - ◆ For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - ◆ For a list of the providers in our network, see the **Provider Directory**.
 - ◆ For a list of the pharmacies in our network, see the **Pharmacy Directory**.
 - ◆ For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at **kp.org/directory**.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - ◆ In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - ◆ To get the details about your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus our plan's Drug List. These chapters, together with the Drug List, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - ◆ If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - ◆ If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - ◆ If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
 - ◆ If you want to ask us to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells you how to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Colorado Department of Public Health and Environment.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends upon the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare:
 - ◆ You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at <https://www.medicare.gov/Pubs/pdf/11534.pdf>.)
 - ◆ Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.10 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

Section 1.11 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions (phone numbers are printed on the back cover of this booklet).

SECTION 2. You have some responsibilities as a member of our plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - ◆ Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - ◆ Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
 - ◆ We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - ◆ To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - ◆ Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible.
 - ◆ Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

- ◆ If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - ◆ You must pay your plan premiums to continue being a member of our plan (see Chapter 1, Section 4.1).
 - ◆ In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B (or Medicare Part B). For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of our plan.
 - ◆ For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your medical services. The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your Part D prescription drugs.
 - ◆ If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - ◆ If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
 - ◆ If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
 - ◆ If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of our plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
 - ◆ If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a special enrollment period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - ◆ If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
 - ◆ If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

- ◆ Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
- ◆ For more information about how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Background 118

SECTION 1. Introduction 118

Section 1.1 What to do if you have a problem or concern 118

Section 1.2 What about the legal terms? 118

SECTION 2. You can get help from government organizations that are not connected with us 119

Section 2.1 Where to get more information and personalized assistance 119

SECTION 3. To deal with your problem, which process should you use? 119

Section 3.1 Should you use the process for coverage decisions and appeals? Or should
you use the process for making complaints? 119

Coverage decisions and appeals 120

SECTION 4. A guide to the basics of coverage decisions and appeals 120

Section 4.1 Asking for coverage decisions and making appeals—*The big picture* 120

Section 4.2 How to get help when you are asking for a coverage decision or making
an appeal 121

Section 4.3 Which section of this chapter gives the details for your situation? 122

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal 122

Section 5.1 This section tells what to do if you have problems getting coverage for
medical care or if you want us to pay you back for our share of the cost of
your care 123

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to
authorize or provide the medical care coverage you want) 124

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of
a medical care coverage decision made by our plan) 127

Section 5.4 Step-by-step: How a Level 2 Appeal is done 130

Section 5.5 What if you are asking us to pay you for our share of a bill you have
received for medical care? 131

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal	132
Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug	133
Section 6.2 What is an exception?	134
Section 6.3 Important things to know about asking for exceptions	135
Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception.....	136
Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)	139
Section 6.6 Step-by-step: How to make a Level 2 Appeal.....	141
SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.....	143
Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights	143
Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	144
Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date	147
Section 7.4 What if you miss the deadline for making your Level 1 Appeal?.....	148
SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	151
Section 8.1 <i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.....	151
Section 8.2 We will tell you in advance when your coverage will be ending.....	151
Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	152
Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	154
Section 8.5 What if you miss the deadline for making your Level 1 Appeal?.....	155
SECTION 9. Taking your appeal to Level 3 and beyond	158
Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals.....	158
Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals	159

Making complaints

161

SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns..... 161

Section 10.1 What kinds of problems are handled by the complaint process? 161

Section 10.2 The formal name for "making a complaint" is "filing a grievance" 162

Section 10.3 Step-by-step: Making a complaint..... 162

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization..... 164

Section 10.5 You can also tell Medicare about your complaint..... 164

Background

SECTION 1. Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3, of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can visit the Medicare website (<https://www.medicare.gov>).

SECTION 3. To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help you with your specific problem or concern, **START HERE:**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

- **Yes, my problem is about benefits or coverage:**

Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

- **No, my problem is not about benefits or coverage:**

Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

SECTION 4. A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals—*The big picture*

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say *no* to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, **contact your State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
 - ◆ For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
 - ◆ For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
 - ◆ There may be someone who is already legally authorized to act as your representative under state law.
 - ◆ If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at <https://www.cms.gov/Medicare/CMS-Forms/CMS->

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Forms/downloads/cms1696.pdf or on our website at **kp.org**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** in this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."
- **Section 7** in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 8** in this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal



Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in the Medical Benefits Chart found at the front of this **EOC**. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells you what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan.
3. You have received medical care or services that you believe should be covered by our plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by our plan, and you want to ask us to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- **Chapter 9, Section 7:** "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Chapter 9, Section 8:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and (CORF) services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section in this chapter, Section 5.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 5.3 in this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 in this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision
 (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an "organization determination."

Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms
A "fast coverage decision" is called an "expedited determination."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making a complaint about your medical care."

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request.**

- However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours.**
 - ◆ However, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - ◆ If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - ◆ You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
 - ◆ You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own, without your doctor's support,** we will decide whether your health requires that we give you a fast coverage decision.
 - ◆ If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - ◆ This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - ◆ The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more

information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - ◆ As explained above, **we can take up to 14 more calendar days** under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - ◆ If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
 - ◆ If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- If our answer is **yes** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- If our answer is **no** to part or all of what you requested, we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request**.
 - ◆ We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - ◆ If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
 - ◆ If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- If our answer is **yes** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3: If we say *no* to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say **no**, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal

(how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms

An appeal to our plan about a medical care coverage decision is called a plan "**reconsideration.**"

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- **To start an appeal, you, your doctor, or your representative must contact us.** For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
 - ♦ If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - ◆ You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - ◆ If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms

A "fast appeal" is also called an " expedited reconsideration. "

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said *no* to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours** after we receive your appeal. We will give you our answer sooner if your health requires us to do so.
 - ◆ However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.

-
- ◆ If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
 - If our answer is **yes** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
 - If our answer is **no** to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - ◆ However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - ◆ If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
 - ◆ If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is **yes** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- If our answer is **no** to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says *no* to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said **no** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say *no* to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours of when it receives your appeal.**
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says **yes** to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- If this organization says **no** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - ♦ If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this

chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see the Medical Benefits Chart found at the front of this **EOC**. We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

We will say *yes* or *no* to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is *yes* at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal



Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this

section.

Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our **Kaiser Permanente 2018 Comprehensive Formulary**. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the **Kaiser Permanente 2018 Comprehensive Formulary**, rules and restrictions on coverage, and cost information, see Chapter 5 ("Using our plan's coverage for your Part D prescription drugs") and Chapter 6 ("What you pay for your Part D prescription drugs") or the Medical Benefits Chart found at the front of this **EOC**.

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a "**coverage determination**."

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - ♦ Asking us to cover a Part D drug that is not on our **Kaiser Permanente 2018 Comprehensive Formulary**.
 - ♦ Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get).
 - ♦ Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our **Kaiser Permanente 2018 Comprehensive Formulary**, but we require you to get approval from us before we will cover it for you.
 - ♦ **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 in this chapter.	You can ask us for a coverage decision. Skip ahead to Section 6.4 in this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 6.4 in this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 6.5 in this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "**exception.**" An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- 1. Covering a Part D drug for you that is not on our Kaiser Permanente 2018 Comprehensive Formulary.** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a " formulary exception. "

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3 (preferred brand-name drugs). You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our **Kaiser Permanente 2018 Comprehensive Formulary** (for more information, go to Chapter 5 and look for Section 4).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a " formulary exception. "

- The extra rules and restrictions on coverage for certain drugs include:
 - ◆ Being required to use the generic version of a drug instead of the brand-name drug.
 - ◆ Getting **plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
 - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms

Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a " tiering exception. "
--

- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "**alternative**" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask

us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say *no* to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do:

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the section called "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

Legal Terms

A "fast coverage decision" is called an " expedited coverage determination. "
--

If your health requires it, ask us to give you a "fast coverage decision"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer **within 72 hours after we receive your doctor's statement**. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
 - ◆ You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - ◆ You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own** (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
 - ◆ If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - ◆ This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - ◆ The letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 in this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - ◆ Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's

statement supporting your request. We will give you our answer sooner if your health requires us to.

- ◆ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is **yes** to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - ◆ Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - ◆ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is **yes** to part or all of what you requested:
 - ◆ If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - ◆ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is **yes** to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say *no* to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal

(how to ask for a review of a coverage decision made by our plan)

Legal Terms

An appeal to our plan about a Part D drug coverage decision is called a plan "**redetermination**."

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - ♦ For details about how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1, "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."**
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - ♦ You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - ♦ If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms

A "fast appeal" is also called an " expedited redetermination. "

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said *no* to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - ♦ If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- If our **answer is yes** to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our **answer is no** to part or all of what you requested, we will send you a written statement that explains why we said *no* and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal**. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.
- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is *yes* to part or all of what you requested:
 - ♦ If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.

- ◆ If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said **no** and how to appeal our decision.

Step 3: If we say *no* to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say **no** to your appeal, you then choose whether to accept this decision or continue by making another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say **no** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said **no** to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the "Independent Review Organization" is the " Independent Review Entity ." It is sometimes called the " IRE ."

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say **no** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government

agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours after it receives your appeal request**.
- If the Independent Review Organization says *yes* to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days after it receives your appeal**.
- If the Independent Review Organization says *yes* to part or all of what you requested:
 - ◆ If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
 - ◆ If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says *no* to your appeal?

If this organization says *no* to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the Medical Benefits Chart found at the front of this **EOC**.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:
 - ◆ Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - ◆ Your right to be involved in any decisions about your hospital stay, and know who will pay for it.

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

- ◆ Where to report any concerns you have about quality of your hospital care.
- ◆ Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can "**request an immediate review.**" Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

- **You must sign the written notice** to show that you received it and understand your rights.
 - ◆ You or someone who is acting on your behalf must sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
 - ◆ Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.
- **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
 - ◆ If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - ◆ To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see it online at **<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>**.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

-
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.

It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (**An Important Message from Medicare About Your Rights**) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date**. (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
 - ♦ **If you meet this deadline**, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - ♦ **If you do not meet this deadline**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "fast review" is also called an "immediate review" or an "expedited review."

Step 2: The Quality Improvement Organization conducts an independent review of your case.*What happens during this review?*

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "Detailed Notice of Discharge." You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227) , 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048 .) Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html .

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.*What happens if the answer is yes?*

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Medical Benefits Chart found at the front of this **EOC**.)

*What happens if the answer is **no**?*

- If the review organization says **no** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your **inpatient hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says **no** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost of hospital care** you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is *no*, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- **You must ask for this review within 60 calendar days** after the day the Quality Improvement Organization said **no** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

*If the review organization says **yes**:*

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

*If the review organization says **no**:*

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is *no*, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms

A "fast review" (or "fast appeal") is also called an " expedited appeal ."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, **go to Chapter 2**, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

*Step 4: If we say *no* to your fast appeal, your case will automatically be sent on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization**

reviews the decision we made when we said **no** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the " Independent Review Entity ." It is sometimes called the " IRE ."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this **organization says yes** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree with us that your planned hospital discharge date was medically appropriate.
 - ◆ The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say **no** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*

This section is **only** about the following types of care:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see the Medical Benefits Chart found at the front of this **EOC**.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - ◆ The written notice tells you the date when we will stop covering the care for you.
 - ◆ The written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a "**fast-track appeal**." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells you how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>.

- You must sign the written notice to show that you received it.
 - ◆ You or someone who is acting on your behalf must sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)
 - ◆ Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with us that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 in this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5 in this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms

This notice of explanation is called the " Detailed Explanation of Non-Coverage. "

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

*What happens if the reviewers say **yes** to your appeal?*

- If the reviewers say **yes** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Medical Benefits Chart found at the front of this **EOC**).

*What happens if the reviewers say **no** to your appeal?*

- If the reviewers say **no** to your appeal, then **your coverage will end** on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **then you will have to pay the full cost of this care yourself.**

Step 4: If the answer to your Level 1 Appeal is *no*, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say **no** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

<p>Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time</p>

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- **You must ask for this review within 60 days** after the day when the Quality Improvement Organization said **no** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request reviewers will decide on your appeal and tell you their decision.

*What happens if the review organization says **yes** to your appeal?*

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

*What happens if the review organization says **no**?*

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is *no*, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "expedited appeal."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself.**

*Step 4: If we say **no** to your fast appeal, your case will automatically go on to the next level of the appeals process.*

- To make sure we were following all the rules when we said **no** to your fast appeal, **we are required to send your appeal to the Independent Review Organization.** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say **no** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said **no** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The **Independent Review Organization** is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - ◆ The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say **no** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 9. Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

- **If the administrative law judge says *yes* to your appeal, the appeals process may or may not be over.** We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - ♦ If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.
 - ♦ If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the administrative law judge says *no* to your appeal, the appeals process may or may not be over.**
 - ♦ If you decide to accept this decision that turns down your appeal, the appeals process is over.

- ◆ If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says **no** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the federal government.

- **If the answer is *yes*, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - ◆ If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
 - ◆ If we decide to appeal the decision, we will let you know in writing.
- **If the answer is *no* or if the Appeals Council denies the review request, the appeals process may or may not be over.**
 - ◆ If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - ◆ If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says **no** to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

- **If the answer is *yes*, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is *no*, the appeals process may or may *not* be over.**
 - ◆ If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - ◆ If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says *no* to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the federal government.

- **If the answer is *yes*, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is *no*, the appeals process may or may *not* be over.**
 - ◆ If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - ◆ If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says *no* to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Making complaints

SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is **only** used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint":

- **Quality of your medical care**
 - ◆ Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
 - ◆ Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
 - ◆ Has someone been rude or disrespectful to you?
 - ◆ Are you unhappy with how our Member Services has treated you?
 - ◆ Do you feel you are being encouraged to leave our plan?
- **Waiting times**
 - ◆ Are you having trouble getting an appointment, or waiting too long to get it?
 - ◆ Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
 - ◆ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
- **Cleanliness**
 - ◆ Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
 - ◆ Do you believe we have not given you a notice that we are required to give?
 - ◆ Do you think written information we have given you is hard to understand?

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4–9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a "complaint" is also called a "grievance."
- Another term for "making a complaint" is "filing a grievance."
- Another way to say "using the process for complaints" is "using the process for filing a grievance."

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly—either by phone or in writing.

- **Usually calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call toll-free **1-800-476-2167 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.

- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
 - ◆ You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint.
We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
 - ◆ You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours.
- **Whether you call or write, you should contact Member Services right away.**
The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."**
If you have a "fast complaint," it means we will give you an answer **within 24 hours**.

Legal Terms
What this section calls a " fast complaint " is also called an " expedited grievance ."

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
 - ◆ The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
 - ◆ To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

CHAPTER 10. Ending your membership in our plan

SECTION 1. Introduction	166
Section 1.1 This chapter focuses on ending your membership in our plan.....	166
SECTION 2. When can you end your membership in our plan?	166
Section 2.1 Where can you get more information about when you can end your group membership?	167
SECTION 3. How do you end your membership in our plan?	167
Section 3.1 There are several ways to end your Senior Advantage membership	167
SECTION 4. Until your membership ends, you must keep getting your medical services and drugs through our plan	168
Section 4.1 Until your membership ends, you are still a member of our plan.....	168
SECTION 5. We must end your membership in our plan in certain situations.....	168
Section 5.1 When must we end your membership in our plan?.....	168
Section 5.2 We cannot ask you to leave our plan for any reason related to your health.....	169
Section 5.3 You have the right to make a complaint if we end your membership in our plan	169
Section 5.4 What happens if you are no longer eligible for group coverage?	169

SECTION 1. Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- **You might leave our plan because you have decided that you want to leave.**
 - ◆ There are only certain times during the year, or certain situations, when you may voluntarily end your membership in our plan. Section 2 tells you when you can end your membership in our plan.
 - ◆ The process for voluntarily ending your membership varies depending upon what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2. When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave our plan during your group's open enrollment period. In certain situations, you may also be eligible to leave our plan at other times of the year. Before you request disenrollment, please check with your group to determine if you are able to continue your group membership.

If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

Section 2.1 Where can you get more information about when you can end your group membership?

If you have any questions or would like more information about when you can end your group membership:

- Contact your group's benefits administrator.
- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You 2018** handbook.
 - ◆ Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
 - ◆ You can also download a copy from the Medicare website (<https://www.medicare.gov>). Or you can order a printed copy by calling Medicare at the number below.

You can contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 3. How do you end your membership in our plan?

Section 3.1 There are several ways to end your Senior Advantage membership

You may request disenrollment by:

- Requesting disenrollment with your group's benefits administrator. You should always consult them before taking any action because it can affect your eligibility for group benefits.
- Calling toll-free **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**, or
- Sending written notice to the following address:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232407
San Diego, CA 92193-2400

SECTION 4. Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information about when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5. We must end your membership in our plan in certain situations

Section 5.1 When must we end your membership in our plan?

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and/or Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - ◆ If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.

- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
 - ◆ If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information about when we can end your membership:

- You can call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10, for information about how to make a complaint.

Section 5.4 What happens if you are no longer eligible for group coverage?

After your group notifies us to terminate your group membership, we will send a termination letter to the subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

- If you are no longer eligible for group membership, you can request enrollment in our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this **Evidence of Coverage** and will include Medicare Part D prescription drug coverage.
- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5.1. For more information or

information about other individual plans, call Member Services. Phone numbers are printed on the back cover of this booklet.

CHAPTER 11. Legal notices

SECTION 1. Notice about governing law.....	172
SECTION 2. Notice about nondiscrimination.....	172
SECTION 3. Notice about Medicare Secondary Payer subrogation rights.....	172
SECTION 4 Administration of this Evidence of Coverage	172
SECTION 5. Amendment of this Agreement	173
SECTION 6. Administration of this Evidence of Coverage	173
SECTION 7. Applications and statements.....	173
SECTION 8. Assignment.....	173
SECTION 9. Attorney and advocate fees and expenses	173
SECTION 10. Coordination of benefits	173
SECTION 11. Employer responsibility.....	174
SECTION 12. Evidence of Coverage binding on members	174
SECTION 13. Government agency responsibility.....	174
SECTION 13. Member nonliability.....	174
SECTION 14. No waiver	174
SECTION 15. Notices	174
SECTION 16. Overpayment recovery.....	175
SECTION 17. Surrogacy.....	175
SECTION 18. Third party liability	175
SECTION 19. U.S. Department of Veterans Affairs.....	176
SECTION 20. Workers' compensation or employer's liability benefits.....	176

SECTION 1. Notice about governing law

Many laws apply to this **Evidence of Coverage** and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2. Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

SECTION 3. Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

SECTION 5. Amendment of this Agreement

Your group's Agreement with us will change periodically. If these changes affect this **Evidence of Coverage**, your group is required to inform you in accord with applicable law and your group's Agreement.

SECTION 6. Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

SECTION 7. 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 **Evidence of Coverage**.

SECTION 8. Assignment

You may not assign this **Evidence of Coverage** or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 9. Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

SECTION 10. Coordination of benefits

As described in Chapter 1 (Section 10) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 18, and for primary payments in workers' compensation cases, see Section 20.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

SECTION 11. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

SECTION 12. Evidence of Coverage binding on members

By electing coverage or accepting benefits under this **Evidence of Coverage**, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this **Evidence of Coverage**.

SECTION 13. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 13. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

SECTION 14. No waiver

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

SECTION 15. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this booklet) and Social Security at **1-800-772-1213 (TTY 1-800-325-0778)** as soon as possible to report your address change.

Note: When we tell your group about changes to this **Evidence of Coverage** or provide your group other information that affects you, your group is required to notify the subscriber within 30

calendar days (or five days if we terminate your group's Agreement) after receiving the information from us.

SECTION 16. 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.

SECTION 17. Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. 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.

SECTION 18. Third party liability

As stated in Chapter 1, Section 10, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services. Note: This Section 18 does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third 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 third 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.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, worker's compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damage claim.

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

Patient Business Services
Kaiser Foundation Health Plan of Colorado
2500 South Havana Street

1-800-476-2167, seven days a week, 8 a.m. to 8 p.m. (TTY 711)

Aurora, CO 80014-1622

Please contact our Patient Business Services Department at **303-743-5900**, or TTY users may call **711**.

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, 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.

SECTION 19. U.S. Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

SECTION 20. Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 10, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From 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.

CHAPTER 12. Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the annual out-of-pocket maximum.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit when you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent **\$5,000** in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles, if applicable. Coinsurance is usually a percentage (for example, 20%) of Plan Charges.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of

care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 10) and Chapter 11 (Section 9) for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. Note: In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is \$1 per day. This means you pay \$1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Dependent – A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Condition – Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to

your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a plan hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a nonpreferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if we limit the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Drug – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family – A subscriber and all of his or her dependents.

Formulary – A list of Medicare Part D drugs covered by our plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Group – The entity with which we have entered into the *Agreement* that includes this **Evidence of Coverage**.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart found at the front of this **EOC**. We cover home health care in accord with Medicare guidelines. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5 % of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible, if applicable, and before your total drug expenses have reached **\$3,750**, including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan of Colorado (Health Plan) – Kaiser Foundation Health Plan of Colorado is a Colorado nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Kaiser Foundation Health Plan of Colorado and the Medical Group.

Kaiser Permanente 2018 Comprehensive Formulary (Formulary or "Drug List") – A list of prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Kaiser Permanente Region – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente region's service area. For more information, please refer to Chapter 3, Section 2.2.

Late Enrollment Penalty – An amount added to the plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head

trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for any contributions toward your group's monthly premium, your Medicare Part A and Part B premiums, and Part D prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Colorado Permanente Medical Group, P.C., a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the

federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services and Customer Experience – Departments within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services and Customer Experience.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, (including but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. We pay network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this **Evidence of Coverage**, *most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply* (see Chapter 5, Section 2.5, for more information).

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See "**Medicare Advantage (MA) Plan.**"

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Plan Charges – Plan Charges means the following:

- For services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.

- For services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this **EOC** and described in Chapter 3, Section 2.3. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial

limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Spouse – Your legal husband or wife.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente 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 Member Services at **1-800-476-2167 (TTY 711)**, 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente does 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 with our Civil Rights Coordinator by writing to 2500 South Havana, Aurora, CO 80014 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. 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, 800-537-7697 (TDD)**. Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**.

Multi-language Interpreter Services

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-476-2167** (TTY: **711**).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-476-2167** (TTY: **711**).

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 **1-800-476-2167** (TTY: **711**)。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-476-2167** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-476-2167** (TTY: **711**).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-476-2167 (TTY: **711**)번으로 전화해 주십시오.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-476-2167** (телетайп: **711**).

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。

1-800-476-2167 (TTY: **711**) まで、お電話にてご連絡ください。

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-800-476-2167** (መስማት ለተሳናቸው: **711**)።

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-476-2167** (TTY: **711**).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-476-2167** (ATS : **711**).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-476-2167** (TTY: **711**) تماس بگیرید.

1-800-476-2167, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **7612-674-008-1** (رقم هاتف الصم والبكم: -117).

Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-476-2167** (TTY: 711).

Cushite-Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-476-2167** (TTY: 711).

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-800-476-2167** (टिटिवाइ: 711) ।

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services - contact information
CALL	1-800-476-2167 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	303-338-3220
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	kp.org

Colorado State Health Insurance Assistance Program

Colorado State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	Contact information
CALL	1-888-696-7213
WRITE	SHIP, Colorado Division of Insurance 1650 Broadway Street, Suite 850 Denver, CO 80202
WEBSITE	https://www.dora.state.co.us/insurance/senior/senior.htm

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)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)

CHIROPRACTIC CARE

1. Coverage

Chiropractic Services are covered as shown on the “Schedule of Benefits (Who Pays What)” when provided by contracted providers. Coverage includes:

- a. Evaluation;
- b. Manual and manipulative therapy of the spinal and extraspinal regions.

You may self-refer for visits to contracted 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 (01-18)

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician 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 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 a Member's 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 Physician, 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 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. Medical Group or 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 Physician 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 Physician, 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 for treatment of cleft lip and cleft palate, as described above.
- 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 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.
- ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless the Member is 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 orthotic devices.
- vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-15)

HEAR0AB

HEARING AID BENEFIT

1. Coverage

For members age 18 and over, a credit per ear, which can be applied toward the purchase of a hearing aid (including ear molds and dispensing fees associated with the hearing aid purchase), is provided as shown on the “ Schedule of Benefits (Who Pays What)” when prescribed by a Plan Physician or audiologist 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.

HEAR0AB (01-15) OPT0AB

OPTICAL BENEFIT

A credit, as shown in the “Vision Services and Optical” section of the “Schedule of Benefits (Who Pays What),” applies toward the purchase of one pair of: (i) regular lenses; (ii) frames; or (iii) contact lenses, including cosmetic lenses, when obtained at a Plan Medical Office and prescribed by a physician or an optometrist. This includes: a \$60 replacement credit for single vision and contact lenses; and \$90 replacement credit for multifocal lenses if a Member's prescription changes .50 diopter or more within 12 months of the initial exam.

Covered Services include:

1. The frame;
2. Mounting of lenses in the frames; and
3. The original fitting and subsequent adjustment of the frame.

The credit must be used at the initial point of sale.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional charge, when obtained at Plan Medical Offices.

EXCLUSION: Replacement of lost or broken lenses or frames.

OPT0AB (01-15)

SNKR0AA

SILVER SNEAKERS FITNESS BENEFIT

A health and fitness benefit is covered and provided at participating fitness or wellness facilities within our Service Area. Health and fitness benefits include:

1. Fitness classes (to improve posture, flexibility and strength).
2. Toning with weights.
3. Aerobic classes.
4. Circuit training.

Additional benefits provided at some facilities include:

1. Swimming.
2. Court sports.
3. Running tracks.
4. Saunas.

You may access Services by taking your current Plan Identification Card to one of the participating fitness facilities within our Service Area and enrolling in the program. To get a list of the participating facilities, please call **Member Services**.

You will be given a one-time activity readiness assessment. Participation in the Fitness Benefit program is dependent upon the result of this assessment and may require a subsequent evaluation at a Plan Medical Office. There is no initiation fee and no monthly dues for participation.

Programs, Services and facilities which carry additional charges such as:

1. Racquetball;
2. Tennis and other court sports;
3. Massage therapy;
4. Lessons related to recreational sports;
5. Tournaments; and
6. Similar fee-based activities;

are excluded.

ELECTIVE ABORTION EXCLUSION

Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are:

1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or
2. When the pregnancy is the result of an act of rape or incest; or
3. Treatment of complications following an abortion.

NOTES

NOTES

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – contact information
CALL	1-800-476-2167 Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.
FAX	303-338-3220
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	kp.org

Colorado State Health Insurance Assistance Program

Colorado State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	Contact information
CALL	1-888-696-7213
WRITE	SHIP, Colorado Division of Insurance 1650 Broadway Street, Suite 850 Denver, CO 80202
WEBSITE	http://www.dora.state.co.us/insurance/senior/senior.htm

**Kaiser Foundation Health
Plan of Colorado**
2500 S. Havana St.
Aurora, CO 80014-1622

3400 *****SCH 5-DIGIT 80222 FSSD

P-7 P38 019004365082



CITY AND COUNTY OF DENVER



Important plan information

EXHIBIT B

Health Plan Wellness Programs



August 17, 2016

City and County of Denver
Heather Britton
201 West Colfax Ave
Denver, CO 80202

Re: Kaiser Permanente HealthWorks Program

Dear Ms. Britton:

This letter constitutes the agreement between Kaiser Foundation Health Plan of Colorado, (KFHP) a Colorado nonprofit, public-benefit, corporation and City and County of Denver (CCD) with respect to the Workforce Health Package to be provided by KFHP to City and County of Denver as described in this letter.

Kaiser Permanente is proud to be a partner of City and County of Denver and we are committed to strengthening our collaboration through improving the health of your employees. City and County of Denver will receive the Workforce Health package for KP subscribers and KP non-subscribers from January 1, 2017 to December 31, 2017 valued at \$100,000. In addition to the allocated funding, you will receive strategic workforce health consulting and 75 coordination hours to support your program. All 2017 programming will be decided upon and added as an appendix (operational plan) prior to December 31, 2016. *Please note wellness programs outside of the Kaiser Permanente menu must be requested and approved by Kaiser Permanente workforce health leadership prior to purchasing program.*

For the 2017 contract year, City and County of Denver had \$200,000 in Workforce Health funding included in their monthly insurance premium rates paid to Kaiser Permanente by City and County of Denver to cover the costs of a third party vendor portal.

Kaiser Permanente agrees to provide the following:

- Workforce Health Consultant
- 75 hours of program coordination and implementation support.
- Employer Health and Wellness will partner with CCD wellness team to develop an operational plan for 2017 which will depict agreed upon programming, dates, communication deadlines, methods of data collection, reports, etc. by November 1, 2016 and will adhere closely to dates set forth. The operational plan will be updated and shared with CCD wellness team as changes to programming are made. Appropriate MOUs will be put into place with CCD once program details are finalized.

City and County of Denver commits to the following:

- Program planning and decisions will be made prior to completion of the operational plan. Any changes to program dates or operational plan from either party will be communicated 4 weeks or more prior to launch. This excludes necessary reschedules resulting from inclement weather and/or unforeseen circumstances.
- All changes to programming as originally set will be communicated to the Employer Health and Wellness team in a timely manner.
- Locations will be secured a minimum of 8 weeks prior to event.
- Any programs requested/proposed will be added separately to this agreement as amendments.

Please indicate your agreement to the terms of this letter agreement by signing this letter in the space indicated and returning it to:

Kaiser Permanente
HealthWorks
10065 E Harvard Ave., suite 250
Denver, CO 80231

Or email to:
Iffie.x.Jennings@kp.org

Signed: _____ Signed: _____

Kaiser Foundation Health Plan of Colorado By: City and County of Denver By:

Title: _____ Title: _____

Date _____, 2016 Date: _____, 2016

City and County of Denver

Re: Kaiser Permanente workforce health programs-2018

This letter agreement ("**Agreement**") memorializes our previous discussions about the Kaiser Permanente workforce health programs that Kaiser Foundation Health Plan of Colorado for the Colorado Region ("**Kaiser Permanente**" or "**KP**") is providing or arranging for City and County of Denver ("**Group**"). KP and Group are collectively the "**Parties**," and each is a "**Party**." The services provided or arranged for under this Agreement are described in Exhibits A (any combination of Exhibits A-1, A-3, A-6, etc.) and are referred to in this Agreement as the "**Services**." The compensation rates applicable to Services are also included in Exhibits A. Exhibit B summarizes the Services chosen by Group and associated compensation rates.

ELIGIBLE GROUP PARTICIPANTS

Services will be available to certain Group participants as determined by Group, and the specific Group participants eligible for each Service are described in the various Exhibits A attached to this Agreement. Group participants include the following categories of participants:

Category of Group Participant	Description
1. KP-Subscribers	Group employees who are members of a KP health plan offered by Group (referred to as " KP-Subscribers ")
2. KP-Subscriber-Dependents	KP-Subscribers' dependents aged 18 or older who are members of a KP health plan offered by Group (referred to as " KP-Subscriber-Dependents ")
3. Non-Subscribers	Group employees who are <u>not</u> members of a KP health plan offered by Group (referred to as " Non-Subscribers ")
4. Non-Subscriber-Dependents	Non-Subscribers' and KP-Subscribers' spouses and domestic partners aged 18 or older who are <u>not</u> members of a KP health plan offered by Group (referred to as " Non-Subscriber-Dependents ")

The eligibility for any particular category of Group participant to access Services may vary by Exhibit and potentially within an Exhibit, and each Exhibit will control as to the availability of a Service to a particular Group participant.

SERVICES UNDER AGREEMENT

The Services are not regulated health plan benefits covered by KP when offered in the manner described in this Agreement. Group retains all responsibility for its group health plans' compliance with applicable law (including, as applicable, the Employment Retirement Income Security Act and its implementing regulations), as well as for its employee wellness programs' compliance with applicable law. KP does not provide legal advice to Group regarding the Services, and Group acknowledges its responsibility to consult with its own professionals for any legal advice regarding the Services.

INFORMATION NEEDED FROM GROUP

Where KP requires information or materials (for example, information about Non-Subscribers or access to space for work-site clinics) to perform its obligations under this Agreement, Group agrees to provide such information and materials (the "**Required Materials**," as described in Exhibits A). KP will have the right (and, if necessary, Group will obtain any third party rights necessary for KP) to copy, modify, and otherwise use Required Materials and any other content, information, records, and materials provided by or for Group to KP for the purpose of KP performing its obligations and exercising its rights under this Agreement. If KP does not receive the Required Materials in the specific manner and according to the terms set forth in this Agreement, KP will be under no obligation to provide the Services that require such Required Materials.

USE OF KP PROPRIETARY MATERIALS

With respect to Services provided by KP, Group acknowledges that, as between the Parties, KP will have all right, title and interest in and to: (a) all content, materials, reports, software and documentation, and any other works of authorship, analytical methodologies, data organization, processes, concepts, systems, know-how, ideas, inventions, and other technology, whether or not confidential, related to the Services, (b) all enhancements, modifications, improvements or derivatives to the foregoing (whether or not created by KP, alone or with others), and (c) all intellectual property rights related to the foregoing (collectively (a), (b) and (c) are referred to as the "**KP Proprietary Materials**"). Group will not acquire any proprietary rights or licenses in the KP Proprietary Materials.

KP grants to Group a non-exclusive, non-assignable, non-sublicenseable, non-transferable right to use any KP Proprietary Materials delivered to it by KP solely in connection with this Agreement. Upon the expiration or termination of this Agreement for any reason, Group will have a non-exclusive, non-assignable, non-sublicenseable, non-transferable right to continue to use the reports containing data as well as health education materials furnished by KP to Group under this Agreement. At all times, Group's use of the KP Proprietary Materials is subject to and conditioned on Group's compliance with the terms and conditions of this Agreement.

TERM AND TERMINATION

This term of this Agreement runs from January 1, 2018 ("**Effective Date**") through December 31, 2018. If Services are still in process at the time of expiration of the term, the Agreement will continue until the Services are fully performed. Either Party may terminate this Agreement with or without cause, upon 60 days written notice to the other Party. Expiration or termination of this Agreement shall not affect those rights, obligations, powers, remedies, and liabilities that arose prior to expiration or termination or are continuing in nature.

NOTICES

All notices, consents, requests, demands or other communications to or upon the respective Parties will be in writing and will be effective for all purposes upon receipt, including without limitation, in the case of (i) personal delivery, (ii) delivery by messenger, express or air courier or similar courier, (iii) delivery by United States first class certified or registered mail, postage prepaid and (iv) transmittal by facsimile, addressed to the respective address provided on the signature page. Changes in address will be communicated pursuant to this paragraph.

COOPERATION

Each Party may use affiliates, consultants or other contractors (together, "**Delegates**") in connection with the performance of its obligations and the exercise of its rights under this Agreement, provided that such Delegate will be subject to those obligations applicable to the delegating Party that are relevant to activities performed by Delegate.

Each Party will perform its obligations under this Agreement in a manner in accordance with all applicable laws and regulations. Where Group provides data on its employees to KP or a Delegate as necessary for performance of Services (for example, data on Non-Subscribers), Group agrees to follow applicable privacy law, including execution of a Business Associate Agreement where required. Each Party will cooperate with and participate in any activities reasonably necessary to assist the other Party in meeting its legal and regulatory obligations with respect to the Services, including cooperation with any review or examination of

the other Party by any governmental agency. Such cooperation and participation will include, without limitation, cooperation with reviews and audits of paper, electronic, or other files, except to the extent inconsistent with applicable law. In accordance with applicable law, KP may use aggregated data and information collected in providing the Services.

Each Party recognizes that the other Party and its affiliates own or have the license to use certain logos, trademarks, service marks and trade names that identify the other Party and its affiliates and contractors and its and their products and services ("Marks"). All goodwill resulting from use of a Party's and its affiliates' and contractors' Marks will inure solely to that Party, its affiliates or contractors, as applicable. Neither Party has acquired, and will not acquire, any right, title or interest in or to the other Party's or its affiliates' or contractors' Marks. Each Party and its affiliates will not register or attempt to register the Marks or any trademark or service mark confusingly similar to the Marks of the other Party, its affiliates or contractors, and will retain the exclusive right to apply for and obtain registrations for its Marks and those of its affiliates throughout the world.

INVOICES

For any amounts owed by Group to KP, KP will submit an invoice to Group describing the Services provided. Group will pay KP within 45 days after receipt of the invoice. Payments will be made in U.S. currency to the KP address provided by KP.

MISCELLANEOUS

This Agreement will be governed in accordance with the laws of the State of Colorado without reference to conflict of laws principles. This Agreement may be executed in separate counterparts, none of which need contain the signatures of both Parties, and each of which, when so executed, shall be deemed an original and all together constitute and be one of the same instrument. The Parties agree that a scanned or electronically reproduced copy or image of this Agreement bearing the signatures of the Parties will be deemed an original and will represent competent evidence of the execution, terms and existence of this Agreement notwithstanding the failure or inability to produce an original, executed counterpart of this Agreement, and without the requirement that the unavailability of such original executed counterpart of this Agreement first be proven. Any determination that any provision of this Agreement or any application thereof is invalid, illegal, or unenforceable shall not affect the validity, legality, and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. This Agreement contains the complete understanding among the Parties with respect to the subject matter of this Agreement and supersedes all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included. All Exhibits to this Agreement are incorporated into this Agreement by this reference. No changes, amendments, cancellation, or modification to this Agreement will be effective unless signed by duly authorized representatives of both Parties.

Please indicate your agreement with the terms of this Agreement by signing the enclosed copy of this Agreement and returning it to iffie.x.jennings@kp.org.

Very truly yours,

"Kaiser Permanente"

Kaiser Foundation Health Plan of Colorado

By: _____

Print Name: _____

Title: _____

Date: _____

Acknowledged and agreed to by:

"Group"

City and County of Denver

By: _____

Print Name: _____

Title: _____

Date: _____

EXHIBIT A-1

WORKSITE BIOMETRIC SCREENINGS AND SERVICES

1. Description of program

With a minimum requirement of thirty (30) Group participants for biometric screenings and flu vaccination clinics, KP will provide the worksite screenings and services described below.

Biometric Screenings and Flu Vaccinations:

Service	Description
Basic Screening Package (non-fasting)	Total cholesterol, High Density Lipoprotein (HDL) Glucose and Blood Pressure
Advanced Package (non-fasting)	Total cholesterol, HDL, Glucose, Blood Pressure, Measured Height & Weight, BMI & Body Fat %
Total Health Assessment Package (fasting required)	Total cholesterol, HDL, Low Density Lipoprotein (LDL), Triglycerides, Glucose, Blood Pressure, Measured Height, Weight & Waist Circumference, BMI and Body Fat %
Wellness Consultation/Coaching	One-on-one sessions with a wellness consultant to help participants understand lifestyle behavior changes that improve screening results
Flu Vaccinations	
Blood Pressure and Pulse Rate	
Measured Height, Weight & Waist Circumference	
Body fat % and BMI (using self-reported ht and wt)	
Glucose (non-fasting)	
Total Cholesterol (non-fasting)	

Group Participants Eligible for this Service

x	KP-Subscribers
	KP Subscriber-Dependents
	Non-Subscribers
	Non-Subscriber-Dependents

2. What needs to be supplied by Kaiser Permanente?

KP will provide the worksite biometric screenings and services noted above, as mutually agreed by the Parties.

3. What needs to be supplied by Group ("Required Materials")?

Group will provide the site location and other identified hardware, as well as at least 6 weeks advance notification of the date the worksite screenings and services are to take place.

4. Fee Schedule
 [Include all that apply]

Service	Price
Screening	
Basic Screening Package (non-fasting)	\$35 per participant
Flu Vaccinations	\$28 per participant
Terms & Conditions	
Fees	<ul style="list-style-type: none"> Total fees may vary by event, based on actual participation, event duration, staffing, event hours, travel fees, class customization, etc. Estimated event fees will be provided when event is scheduled. Total actual fees will be detailed on a post-event invoice, as applicable. <ul style="list-style-type: none"> Additional staffing fees apply to services provided weekdays after 6:00 p.m. and before 7:00 a.m., and any time during weekends. Additional fees may apply for non-standard event duration and/or non-standard staffing levels Travel fees may apply, depending on event location, and will be quoted when event is scheduled. Screenings priced hourly are subject to a 3-hour minimum, billed at \$75 per staff hour. The full hourly rate will be charged for any partial hour. Wellness Consultations are subject to 3-hour minimum per consultant. The full hourly rate will be charged for any partial hour. Screenings and flu vaccination clinics will be charged at a minimum of 30 participants or 80% of estimated participation, whichever is greater, plus any additional fees if applicable.
Scheduling Guidelines	<ul style="list-style-type: none"> All service requests must be submitted at least 6 weeks in advance in order to comply with permit application deadlines and staff scheduling lead-time. Requests submitted with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed. Requests to <u>increase</u> number of attendees or event duration less than 10 business days before scheduled event date will be accommodated if possible, though cannot be guaranteed. Premium freight fees and supplemental staffing fees may apply. Requests to <u>decrease</u> number of attendees or event duration less than 10 business days before scheduled event date cannot be accommodated. In such cases, billing will be based on most recent participation estimate and event schedule provided before 10 business day cutoff. Requests to change event type less than 10 business days before scheduled event date will be accommodated if possible, though cannot be guaranteed. If requested changes cannot be accommodated, Group may reschedule, subject to rescheduling fee described below, or proceed with services confirmed before 10 business day cutoff.
Cancellation and Rescheduling	<ul style="list-style-type: none"> If a confirmed event is cancelled less than 10 business days before event date, 50% of the total estimated event fees will be charged. However, if a confirmed event is cancelled less than 5 business days before event date, 100% of total estimated event fees will be charged. If a confirmed event is rescheduled less than 10 business days before event date, 25% of total event fees will be charged in addition to actual cost of rescheduled

	event. Rescheduling requests are subject to the 6 week lead-time described above. Rescheduling requests with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.
--	--

Credits

In connection with KP's mission to promote wellness in the community, the following credits will be applied to the Group's fees.

Services covered by credits	Screening package
Maximum Credit	\$10,000
Time Period	January 1, 2018-December 31, 2018

EXHIBIT A-2

HEALTH PROMOTION PROGRAMS, CLASSES, AND WORKSHOPS

1. Description of the Program

KP will provide the health promotion services described below:

Health Promotion Programs:

Service	Descriptions	# Sessions
Back Care	Participants learn ways to keep their back as healthy as possible and avoid back problems by learning the basics in this interactive program. Participants will also learn basic back anatomy, posture, and work positioning that is beneficial to maintaining a healthy back	
Get Moving	Participants will learn guidelines for physical activity, the different types of physical activity, and explore ways to increase motivation and overcome barriers.	
Healthy Eating	Participants learn the principles of good nutrition as they apply to basic good health and help to lower the risk of developing certain chronic conditions. This class is quite helpful for those wishing to further improve control of conditions such as diabetes, heart disease, hypertension, and weight management.	
Quit Tobacco	Prepares participants to quit smoking by assessing their readiness, teaching them about the quitting process and developing their own quit plan.	
Stress Reduction	Describes the participant's body's "stress response," how to identify stress, and help combat these effects by providing an overview of stress management skills.	
Weight Management	Provides participants with an understanding of weight management principles, how to judge fad diets, diet aids, and to identify the behavioral aspects of weight control.	
Healthy Habits	Healthy living includes motivation, health change, and goal setting. After choosing a behavior they want to target – from exercise to flossing – participants will learn how to strengthen their motivation and make behavior changes that stick.	
Healthy Sleep	Sleeping well is vital to good health, well-being, and job performance. Participants will learn strategies to get the best night's sleep.	

Group Participants Eligible for this Service

x	KP-Subscribers
	KP Subscriber-Dependents
x	Non-Subscribers
	Non-Subscriber-Dependents

2. What needs to be supplied by Kaiser Permanente?

KP will provide Health Promotion Programs, Classes and Workshops on the dates and in the locations as mutually agreed by the Parties.

3. What needs to be supplied by Group (“Required Materials”)?)

Group will provide the site location, room, projector, and other identified hardware.

4. Fee Schedule

Service	Price
Classes	
Single-Session Class	<ul style="list-style-type: none"> • \$375 per one hour session • For extended class greater than one hour, \$375 per portion of hour after first hour
Terms & Conditions	
Fees	<ul style="list-style-type: none"> • Total fees may vary by event, based on actual participation, event duration, staffing, event hours, travel fees, class customization, etc. Estimated event fees will be provided when event is scheduled. Total actual fees will be detailed on a post-event invoice, as applicable. <ul style="list-style-type: none"> ○ Additional staffing fees apply to services provided weekdays after 6:00 p.m. and before 7:00 a.m., and any time during weekends. ○ Additional fees may apply for non-standard event duration and/or non-standard staffing levels ○ Travel fees may apply, depending on event location, and will be quoted when event is scheduled. • Class participation is limited to 50 participants unless otherwise arranged at time of scheduling. Additional fees may apply for additional participants. • Additional fees may apply for customized classes and supplemental class materials which will be quoted at time of event scheduling.
Scheduling Guidelines	<ul style="list-style-type: none"> • All service requests must be submitted at least 6 weeks in advance in order to comply with staff scheduling lead-time. Requests submitted with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed. • Requests to <u>increase</u> number of participants greater than 50 participants that are submitted less than 10 business days before the scheduled event date will be accommodated if possible, though cannot be guaranteed. Supplemental staffing and material fees may apply. • Requests to <u>decrease</u> number of participants (if original request is greater than 50 participants) that are submitted less than 10 business days before the scheduled event date cannot be accommodated. In such cases, billing will be based on most recent participation estimate and event schedule provided before the 10 business day cutoff. • Requests to change class topic less than 10 business days before the scheduled event date will be accommodated if possible, though cannot be guaranteed. If requested changes cannot be accommodated, Group may reschedule subject to

	rescheduling fee described below, or proceed with services confirmed before 10 business day cut off.
Cancellation & Rescheduling	<ul style="list-style-type: none"> • If a confirmed event is cancelled less than 10 business days before event date, 50% of the total estimated event fees will be charged. • However, if a confirmed event is cancelled less than 5 business days before event date, 100% of total estimated event fees will be charged. • If a confirmed event is rescheduled less than 10 business days before event date, 25% of total event fees will be charged in addition to actual cost of rescheduled event. Rescheduling requests are subject to the 6 week lead-time described above. Rescheduling requests with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.

Credits

In connection with KP's mission to promote wellness in the community, the following credits will be applied to the Group's fees.

Services covered by credits	Health Promotion classes
Maximum Credit	\$10,000
Time Period	January 1, 2018-December 31, 2018

EXHIBIT A-3
FACILITATED CONNECTIONS WITH OTHER WELLNESS COMPANIES

Curated Plus Arrangements

KP will facilitate Group's introduction to other wellness companies and will offer access for Group to KP's negotiated pricing for their services.

Wellness Company	Description of Services
Fruit Guys	Fresh Fruit Delivery Service
Health Enhancement Systems	Ready to implement wellness challenges including fitness, nutrition, weight control, stress management, and other health campaigns.
My Brain Solutions	Online emotional wellness solution

Group Participants Eligible for this Service

x	KP-Subscribers
	KP Subscriber-Dependents
X	Non-Subscribers
	Non-Subscriber-Dependents

Fee Schedule

Wellness Company	Fee Schedule
Health Enhancement Systems	Price varies based on program.
My Brain Solutions	\$ 0.32 PMPM
My Brain Solutions One time set up for customizing web site and communication materials 1. Implementation 8-week plan 2. Engagement Strategies 3. Communication Tools 4. Reporting	\$2,500
My Brain Solutions Optional Single Sign On set up service to allow for ease of web access	\$2,500

Payment

As part of KP's mission to promote wellness in the community, KP agrees to credit Group for certain costs actually incurred by Group for eligible wellness services provided by the wellness companies and during the time period(s) noted below, up to the maximum dollar amount specified below. In the event that the fees for these wellness services to Group's participants exceed the maximum credits provided by KP, KP will invoice Group for the difference.

Name of Wellness Company Eligible for KP Credit	Dates of Service During Which KP Credit is Eligible	Maximum amount of KP Credit to Group for these Services
My Brain Solutions	January 1, 2018-December 31, 2018	\$50,000
Health Enhancement Systems	January 1, 2018-December 31, 2018	\$10,000

EXHIBIT A-4

Wellness Ambassador Program

1. Description of Program

The Wellness Ambassador Program is a 9-week training curriculum that trains selected Group employees to become "Wellness Ambassadors" for other employees by enhancing knowledge about basic health and wellness and health insurance coverage. Through the Wellness Ambassador Program, employees will learn through practical class instruction, role playing and knowledge checks, how to become peer advocates and take the Group's existing wellness committee to the next level by creating a sustainable, onsite, social support system that influences healthy behavior change and enhances employee engagement.

Service:	Description:
1. Peer Wellness Coaching	Highlights roles, responsibilities, and provides education on the peer coaching model while initiating team building
2. Motivational Interviewing	Identifies basic elements of Motivational Interviewing (active listening, persuasion, etc.), and how to incorporate basic elements of MI into the Wellness Ambassador role
3. Health Plan 101	Familiarizes participants with health/wellness benefits, resources, and portals for all plans (for example KP members must be registered on kp.org and familiar with organization, content, tools, etc.)
4. Ready, Set, Goal	Facilitator leads participants in considering a health behavior change they have thought about making, identifying internal motivations, walking through the change process, and deciding on next steps
5. Stress Less	Provides an overview of how body, mind and symptoms are connected. Participants learn to identify sources of stress and the coping skills to help manage them.
6. Eating Well	Educates on principles of good nutrition as they apply to basic good health, including how a healthier diet can lower the risk of developing certain chronic conditions
7. Get Moving	Educates on the benefits of activity and how to develop an exercise plan, overcome barriers, and stay motivated
8. Weight Management	Educates on how healthy lifestyle choices and a positive attitude can help with weight loss and weight maintenance
9. Review and Graduation	Review of the previous 8 weeks of curriculum and graduation

Group Participants Eligible for this Service

x	KP-Subscribers
	Non-Subscribers

2. What needs to be supplied by Kaiser Permanente?

KP will provide classes on the dates and at the locations as mutually agreed by the Parties.

3. What needs to be supplied by Group (“Required Materials”)?

Group will provide the site location, room, projector, and other identified hardware.

4. Fee Schedule

Service	Price
Class instruction and materials (for up to 25 people)	<ul style="list-style-type: none"> \$5,000
Terms & Conditions	
Scheduling Guidelines	<ul style="list-style-type: none"> All service requests must be submitted at least 6 weeks in advance in order to comply with staff scheduling lead-time. Requests submitted with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.
Cancellation & Rescheduling	<ul style="list-style-type: none"> If a confirmed event is cancelled less than 10 business days of event date, 50% of the total estimated event fees will be charged. If a confirmed event is cancelled less than 5 business days of event date, 100% of total estimated event fees will be charged. If a confirmed event is rescheduled less than 10 business days of event date, 25% of total event fees will be charged in addition to actual cost of rescheduled event. Rescheduling requests are subject to the 6 week lead-time described above. Rescheduling requests with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.

Credits

In connection with KP's mission to promote wellness in the community, the following credits will be applied to the Group's fees.

Services covered by credits	Wellness Ambassador Program
Maximum Credit	\$25,000
Time Period	January 1, 2018-December 31, 2018

EXHIBIT C

Logo Guide



DENVER
THE MILE HIGH CITY

CITY AND COUNTY OF DENVER LOGO GUIDELINES



These guidelines demonstrate how to correctly use
the City and County of Denver logo.

UPDATED 2016



CONTENTS

- 1 Who Can Use the City and County of Denver Logo**
- 2 Primary and Secondary Logos**
- 3 Clear Zone, Minimum Sizes & Typefaces**
- 4 Logo Colors**
- 5 Reverse & One-Color Usage**
- 6 Incorrect Usage**
- 7 The City Flag & the City Seal**
- 8 Offices Within the City**
- 9 Letterset**
- 10 Email Signatures & Mobile Guidelines**
- 11 Program, Venue & Event Logos**
- 12 Expanded Palette**
- 13 Expanded Palette: Suggested Usage**
- 14 Allied Organizations & Co-Branding**
- 15-16 Glossary of Terms**

TYPES OF LOGO FILES

EPS

Vector-based image that will not lose quality if scaled larger than the provided size. Available in four color process, spot color and black and white. Primarily used for professional printing.

JPEG

Both high and low-resolution pixel-based images that will lose quality if scaled larger than the provided size. Available in RGB format and black and white. Primarily used for in-house printing and for viewing on screen. This is also the preferred format for programs that are not design-based, such as Microsoft Word, Microsoft Excel, and Microsoft PowerPoint.

TYPES OF LOGO COLORS

Spot Color

Spot color printing uses pre-mixed ink colors determined by the Pantone Matching System (PMS). They accurately represent color chips provided to the print and design industry.

4 Color Process

Process printing uses four inks (cyan, magenta, yellow and black — also referred to as CMYK) printed together to create a wide spectrum of colors.

RGB Format

Colors are used in RGB (red, green and blue) format when they appear on computer or television screens.

Hex Numbers

Hexadecimal numbers or “hex” numbers are a base-16 numbering system used to define colors on web pages. A hex number is written from 0-9 and then A-F.

For copies of the logo in any format or questions about which file type you need, please contact the Denver Marketing Office at DenverMarketingOffice@DenverGov.org or 720-913-1633.



WHO CAN USE THE CITY AND COUNTY OF DENVER LOGO



The Denver D logo is available for use by city employees of the City and County of Denver for city department/agency purposes. The Denver logo may not be distributed to external entities (with the exception of the partnering agencies described below) without a licensing agreement.

The Denver D logo may be distributed to entities with which the City and County of Denver has executed a contract that includes, at a minimum, the following terms and conditions: required usage guidelines to include duration of use; purpose of use; and the corresponding collateral in which the Denver D logo will be placed. Licensing agreements may be obtained through the Denver Marketing Office and are subject to Executive Order No. 8.

For an outside entity to be considered for a licensing agreement authorizing them to use the Denver D logo, the city must be playing an active role in event or partnership or have a paid, documented sponsorship agreement. When the city does enter into a relationship as a sponsor, the sponsorship package must include phrasing that defines the acknowledgement of city support through the use of its logo to be eligible. For a copy of the city's sponsorship agreement please contact the Denver Marketing Office.

The city does not provide use of the logo for events or initiatives for which the city has supplied grant-funded support unless the event or initiative has a corresponding documented sponsorship component or agreement. If the city has provided a grant to an outside entity, that entity may recognize city support through written or spoken word unless the grant or contract providing grant funds provides otherwise.

The City and County of Denver does grant permission to use the Denver D logo to the city's exclusive partners, such as the VISIT DENVER, the Convention and Visitors Bureau and the Downtown Denver Partnership. All partnering agencies must follow the usage guidelines as described in the graphic standards. Distribution of the logo to outside entities by partnering agencies is unacceptable.



PRIMARY AND SECONDARY LOGOS



The City and County of Denver logo consists of three main elements: The primary D icon, the DENVER logotype and tagline.

Each of these elements has been custom-created and should never be recreated or re-typeset. To maintain consistency and create a strong visual identity, the Denver logo should only be used from existing digital files.

Please **DO NOT** use the Denver D icon without the DENVER logotype and tagline unless expressly permitted by this guide or the Denver Marketing Office.



PRIMARY LOGO

The horizontal version of the Denver logo (D icon to the left of the logotype) is the preferred logo format.

The logo utilizes the typeface Avenir Black for both DENVER and the tagline.

The distance to the right of the D icon and to left of the type should remain consistent. This distance is determined by the distance between the bottom of the tagline to the bottom of the DENVER logotype, represented by the letter X. The distance from the right edge of the D icon to the left edge of the logotype should be equal to X. The block of text in its entirety is centered vertically with the D icon.



SECONDARY LOGO

When the horizontal version of the Denver logo will not work with your space or design requirements, the secondary, stacked logo version can be used. Again, the distance between the bottom of the D icon and top of the DENVER logotype should be equal to X. The block of text in its entirety is centered horizontally with the D icon.



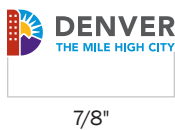
CLEAR ZONE, MINIMUM SIZES & TYPEFACES



CLEAR ZONE

The Denver logo should always have an area of open space or “clear zone” around it. No other graphic elements should fall within this area around the logo.

Where “X” is equal to the distance between the bottom of the tagline to the bottom of the DENVER logotype, leave at least X amount of clearance on all sides of the logo.



MINIMUM SIZES

The Denver logo should always be used at an appropriate size to make sure it is legible.

When the primary signature is used, it should be no smaller than 7/8” wide at the widest point. The secondary signature should be used no smaller than 5/8” at its widest point.

ITC Franklin Gothic Demi

ABCDEFGHIJKLMNOPQRSTUVWXYZ
 abcdefghijklmnopqrstuvwxyz
 1234567890@#\$\$%^&*!/?/;:.”{}[]()

ITC Franklin Gothic Book

ABCDEFGHIJKLMNOPQRSTUVWXYZ
 abcdefghijklmnopqrstuvwxyz
 1234567890@#\$\$%^&*!/?/;:.”{}[]()

TYPEFACES

The primary typeface used to accompany the Denver logo is ITC Franklin Gothic.

There are two typefaces in this family that are commonly used for Denver branded materials: Franklin Gothic Demi and Franklin Gothic Book.

Standard fonts such as Arial are permitted within documents created in programs where custom fonts are not available.








LOGO COLORS



The Denver logo color palette is comprised of five colors that represent this vibrant city.

Spot-color printing is the preferred option and should be used whenever possible. However, four-color process printing may be used when spot-color printing is not available or cost effective. When the logo is used on the on screen, the RGB format should be used and hex values should be used for the web. The Denver logo spot colors and their corresponding four-color process, RGB and hex formulas are listed below.

The color samples in this guide are just a visual representation of the colors and should not be used as an accurate color match. Actual Pantone chips should be used to match colors when printing.

	SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
 BRICK RED	PMS 1805	C 0 M 91 Y 100 K 23	R 160 G 0 B 34	#C4161C
 SKY BLUE	PMS 2925	C 85 M 24 Y 0 K 0	R 0 G 150 B 214	#0096D6
 SUNSHINE GOLD	PMS 130	C 0 M 30 Y 100 K 0	R 253 G 185 B 19	#FDB913
 MOUNTAIN PURPLE	PMS 268	C 82 M 100 Y 0 K 12	R 64 G 15 B 96	#491D74
 80% BLACK	PANTONE PROCESS 80% BLACK PMS 425	C 0 M 0 Y 0 K 80	R 88 G 89 B 91	#58595B

Pantone® is a registered trademark of PANTONE Inc.'s color matching system.

Note: Palette colors pertain to both coated and uncoated stocks



REVERSE & ONE-COLOR USAGE



15%



50%



70%

FULL-COLOR REVERSE USAGE

A reverse version of the Denver logo has been developed for use when the logo appears on black or other dark colors. The D is not actually reversed, but uses a white border to separate it from the background. The logotype and tagline are white instead of black to increase legibility.

Use the regular signature on backgrounds with a color that has a tonal equivalency of 15% or less black and the reverse signature on backgrounds with a color that has a tonal equivalency of more than 15% black.



ONE-COLOR USAGE

An alternate version of the Denver logo has been developed to be used when only one color is available.

One-color logos should only be used as an alternative to the preferred full-color version. It should not be used in four-color process printing or in RGB formats, where you can use a full-color version instead.



ONE-COLOR REVERSE USAGE

When only one color is available and the logo appears on black or another dark color, a one-color reverse usage should be used. In this version, the primary D icon is used with a white border with the colored elements reversed to the background color.



INCORRECT USAGE



DO NOT reposition the elements of the logo.



DO NOT use the one-color reversed logo where the primary icon appears in solid white (see page 5 for the correct usage).



DO NOT change the colors of the logo.



DO NOT distort or stretch the logo. Make sure it is always scaled proportionally.



DO NOT use the primary D icon as a decorative capital letter.



DO NOT place the logo on a background without sufficient contrast (see reverse applications on page 5).



DO NOT place the logo on a photographic background without sufficient contrast (see reverse applications on page 5).



DO NOT use the logo without all of the necessary elements.



DO NOT use the logo or primary icon in a way that violates the minimum clear space, especially in a co-branding situation.



DO NOT use the D icon locked up with any other typeface.



THE CITY FLAG AND THE CITY SEAL



THE CITY FLAG

The city flag graphic is not to be used as a replacement for the Denver D logo. The city flag image is to be associated only with an actual flag representing the City and County of Denver. All materials currently showcasing the city flag as a graphic image need to be phased out and replaced with the D logo (e.g., employee badges, city vehicles, brochures, etc.).

The city flag image is protected by common law rights.



THE CITY SEAL

The city seal is to be reserved for official city documents. Official documents include, but are not limited to, mayoral proclamations, legal documents and death certificates.

To the extent reasonable, city agencies and departments must transition to the updated business systems package for regular city business. The business system package includes letterhead, envelopes, and business cards which are available on the brand center. As appropriate, all marketing, informational and informal material – including websites, uniforms, brochures and other collateral material – should include the Denver D logo and exclude the city seal.

If you have any questions regarding logo usage policies please contact the Denver Marketing Office. If you have any questions regarding legal considerations around the use of the city seal, please contact the City Attorney's Office.



OFFICES WITHIN THE CITY

Offices within the city are able to use their own unique logo, as outlined below. It is also acceptable for the office to use the main City and County of Denver logo if they choose.



DEPARTMENTS AND AGENCIES

To maintain the integrity of the City and County of Denver logo when branding departments, offices and agencies within the city, the logo will still be comprised of three elements. The D icon and DENVER logotype will remain, but the name of the department will take the place of the tagline, THE MILE HIGH CITY. Please keep the DENVER logotype alignment the same as the main City and County of Denver logo.



When the name of the department is too long to fit onto one line, the text should flow to the second (or third, if applicable) line. The top of the department name will remain on the same level. Please try to split the name evenly onto two lines, and do not extend the name of the department further than approximately 50% beyond the length of DENVER. Please refer to **page 5** for reverse and one-color usage.

Please do not use the word “DENVER” in department name to avoid redundancy, and acronyms in the department name should be avoided whenever possible.



DIVISIONS WITHIN DEPARTMENTS AND AGENCIES

When branding programs that are contained within the city’s departments, offices and agencies, a new type configuration applies. The name of the program is set first in the position and ratio indicated below. The name of the parent department, office or agency moves to the second line, and always follows the word “Denver.”



If the name of the program is too long to fit onto one line, it should flow to the second line.



As with the primary Denver logo, the distance to the right of the D icon and to left of the type should remain consistent within program logos. Note that in these applications, all text elements move to align to the top of the D icon.

TAGLINES

Please do not lock up taglines, mission statements, etc. to the logo when creating an office’s identity.


EXCEPTIONS

The three divisions of the Department of Safety and Denver International Airport are the only city offices that are permitted to continue using independent logos. The Denver D logo should still be co-branded with these agencies whenever appropriate.



LETTERSET

Align letter with left side of DENVER and tagline type


1.75"

Agency/Department Name
Street Address | Denver, CO Zip
www.denvergov.org/department name
p: xxx.xxx.xxx | c: xxx.xxx.xxx | f: xxx.xxx.xxx

311 | POCKETGOV.COM | DENVERGOV.ORG | DENVER 8 TV

1.25"





LETTERHEAD

This letterhead has also been set up as a Microsoft® Word template.

If the document is released from multiple divisions, please typeset only the primary department/agency contact information centered across the bottom to avoid confusion and maintain the specified layout.


When typing a letter, align the left side of the text with the left side of the DENVER and tagline typography and begin typing 1.75" from the top of the page.

Leave a 1.25" margin at the bottom of the page to accommodate contact information.

<div style="display: flex; justify-content: space-between; align-items: center;">  </div> <p style="font-size: 0.8em;"> Firstname Lastname Job Title Division, Agency/Department Name p: xxx.xxx.xxx Street Address c: xxx.xxx.xxx Denver, CO Zip f: xxx.xxx.xxx firstname.lastname@denvergov.org www.denvergov.org/agencyname </p> <div style="background-color: #0070C0; color: white; padding: 2px; font-size: 0.7em; text-align: center;"> 311 POCKETGOV.COM DENVERGOV.ORG DENVER 8 TV </div>	<div style="display: flex; justify-content: space-between; align-items: center;">  </div> <p style="font-size: 0.8em;"> Firstname Lastname Job Title Division, Agency/Department Name p: xxx.xxx.xxx Street Address c: xxx.xxx.xxx Denver, CO Zip f: xxx.xxx.xxx firstname.lastname@denvergov.org www.denvergov.org/agencyname </p> <div style="background-color: #C00000; color: white; padding: 2px; font-size: 0.7em; text-align: center;"> 311 POCKETGOV.COM DENVERGOV.ORG DENVER 8 TV </div>
<div style="display: flex; justify-content: space-between; align-items: center;">  </div> <p style="font-size: 0.8em;"> Firstname Lastname Job Title Division, Agency/Department Name p: xxx.xxx.xxx Street Address c: xxx.xxx.xxx Denver, CO Zip f: xxx.xxx.xxx firstname.lastname@denvergov.org www.denvergov.org/agencyname </p> <div style="background-color: #4B0082; color: white; padding: 2px; font-size: 0.7em; text-align: center;"> 311 POCKETGOV.COM DENVERGOV.ORG DENVER 8 TV </div>	<div style="display: flex; justify-content: space-between; align-items: center;">  </div> <p style="font-size: 0.8em;"> Firstname Lastname Job Title Division, Agency/Department Name p: xxx.xxx.xxx Street Address c: xxx.xxx.xxx Denver, CO Zip f: xxx.xxx.xxx firstname.lastname@denvergov.org www.denvergov.org/agencyname </p> <div style="background-color: #FFC000; color: white; padding: 2px; font-size: 0.7em; text-align: center;"> 311 POCKETGOV.COM DENVERGOV.ORG DENVER 8 TV </div>

BUSINESS CARDS

Visit the Brand Center at www.denvergov.org/brandcenter for electronic files and pre-printed shells. Do not attempt to recreate the business card artwork. Please do not add logos or other artwork to the back of the card.



Department/Agency Name
Division Name
Street Address
Denver, CO Zip

311 | POCKETGOV.COM | DENVERGOV.ORG | DENVER 8 TV

#10 ENVELOPE

Visit the Brand Center at www.denvergov.org/brandcenter for electronic files and pre-printed shells. Do not attempt to recreate the envelope artwork.

For additional templates not provided within this document (i.e. pocket folders, press releases, presentations, etc.) please contact the Denver Marketing Office.



EMAIL SIGNATURES AND MOBILE GUIDELINES



DENVER
THE MILE HIGH CITY

First Name N. Lastname | Job Title
Division, Agency/Department | City and County of Denver
p: (xxx) xxx-xxxx | name.name@xxxxxxxxxxdenvergov.org

CONNECT WITH US | 311 | pocketgov.com | denvergov.org | Denver 8 TV | Facebook

EMAIL SIGNATURES

Email signatures should feature the horizontal version of the City and County of Denver logo below the email sender's information. Directly below this, the signature should additionally contain the city's four connection touch-points as illustrated in the example image on the right. This text graphic represents the four most common ways in which residents connect with the city for services, schedules, and information.

Please use a text-only version of the signature when responding to email changes so as not to unnecessarily increase the message file size. Agency or department specific logos, per page 8, are permitted in email signatures. However, it is the sole responsibility of the communications director in each department to create and distribute these templates in order to ensure that the graphic standards are maintained.

Personal quotes, background colors and patterns, etc., should not be used in the email signature. However, department mission statements are acceptable when necessary. It is also permissible to add certain standardized language, such as legal disclosure policies or requests to minimize paper usage.

Please note that Arial is used in place of Franklin Gothic in this application because it is a web-safe font.

Please refer to the [Denver Brand Center](#) to properly set up your email signature.



APP ICONS

Departments, agencies, divisions and programs within the City and County of Denver may have the opportunity to create mobile apps. When doing so, any primary, secondary or accent color can be utilized.

Glyph icons are used for mobile application toolbars, splash screens, navigation, and menus. Mobile application glyph icons must be designed as monochromatic symbols with an emphasis on minimalism and simplicity. Mobile app icons must provide easy recognition in formats as small as 32 x 32 pixels and must adhere to all size standards provided by the specific mobile application framework (iOS, Android, Windows Phone, etc.). They should be developed in vector format to be scalable up or down, depending on the required specifications.

The app icon should feature a simple, representative image reversed out on a city color. The icon should feature a solid color border and an embossed effect to give it dimension. Examples are at left; please note that customized icons should be approved by the Denver Marketing Office before they are used.



PROGRAM, VENUE AND EVENT LOGOS



Any office operating solely under the City and County of Denver, exclusively funded with taxpayer dollars and/or at the direction of the mayor should be using the Denver D as its primary logo. However, there are instances when a city program, venue or event may merit its own visual identity, such as in the case of a partnership with an external entity, when the initiative needs to be marketed broadly, or when legal or political considerations make the Denver D less preferred. In those scenarios, some basic quality assurances should be considered.

Please contact the Denver Marketing Office before a new logo is created.

Some guidelines to consider when designing a new program identity:

■ Logos & Symbols

Style matters. The symbol reflects Denver's energy, the amazing weather, outdoor lifestyle and economic vitality through the incorporation of the shining sun, blue skies, majestic mountains and downtown landscape. When creating a new program identity, try to be compatible with the design feel established by the Denver "D" icon.

■ Brand Recognition

It's important for our audiences to understand which programs are affiliated with the city. Please use the City and County of Denver logo and identity prominently on all materials. In applications where the Denver D cannot be featured prominently, such as on an independent website, please include prominent text explaining the affiliation with the city (e.g. "Red Rocks Amphitheater is a proud venue of the City and County of Denver.")

■ Co-Branding

Consider what other logos will appear with the new one and try to complement, instead of compete with them.

■ Color Palette

Always use colors from the approved palette. See page 12 for expanded colors.

■ Typefaces

When it comes to font personality, a little goes a long way. Try to stay within the Franklin Gothic font family when possible.

■ Simplification

Logos should rarely have more than a couple colors and distinct elements (mark, typeface, tagline).

■ Scalability

Logos should have the ability to be used in very large or very small formats, meaning that high resolution versions should be developed and too many elements should be avoided.

■ Section 508 Web Color Contrast

Web Content Accessibility Guidelines (WCAG 1.0) require that there be a sufficient level of tonal contrast between colors so that low-vision users can read content on colored backgrounds. Guidelines for ensuring color combinations include:

- Select color combinations that can be differentiated by users with color deficiencies;
- Use tools to see what color combinations will look like when in black and white as seen by color-deficient users;
- Ensure that the lightness contrast between foreground and background colors is high;
- Increase the lightness contrast between colors on either end of the spectrum (e.g., blues and reds); and
- Avoid combining light colors from either end of the spectrum with dark colors from the middle of the spectrum.

Please contact the Denver Marketing Office with any questions regarding program identity best practices.



EXPANDED PALETTE



Although the main logo is comprised of five colors, city programs may use colors in the expanded palette for identity development and other graphic design. The expanded palette includes four secondary colors and four accent colors.

PRIMARY PALETTE

SPOT COLOR (PANTONE)



PMS 1805

BRICK RED



PMS 2925

SKY BLUE



PMS 130

SUNSHINE GOLD



PMS 268

MOUNTAIN PURPLE



PANTONE
PROCESS
80% BLACK

80% BLACK

SECONDARY PALETTE

SPOT COLOR (PANTONE)



PMS 384

YELLOW GREEN



PMS 294

BRIGHT BLUE



PMS 152

ORANGE



PMS 180

RED ORANGE

4 COLOR PROCESS (CMYK)

C 18
M 0
Y 100
K 31

C 100
M 58
Y 0
K 21

C 0
M 51
Y 100
K 1

C 0
M 79
Y 100
K 11

RGB

R 159
G 166
B 23

R 0
G 85
B 150

R 243
G 144
B 29

R 217
G 83
B 30

HEX COLOR (WEB)

#9FA617

#005596

#F3901D

#D9531E

ACCENT COLORS



PMS 296

NAVY

C 100
M 46
Y 0
K 70

R 0
G 45
B 86

#002D56



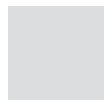
PMS 7496

BRIGHT GREEN

C 40
M 0
Y 100
K 38

R 109
G 141
B 36

#6D8D24



PMS 420

LIGHT GRAY

C 0
M 0
Y 0
K 15

R 220
G 221
B 222

#DCDDDE



PMS 7501

CREAM

C 0
M 4
Y 20
K 6

R 241
G 227
B 197

#F1E35C

Pantone® is a registered trademark of PANTONE Inc.'s color matching system.

Note: Palette colors pertain to both coated and uncoated stocks



EXPANDED PALETTE: SUGGESTED USAGE



When selecting colors for a new program identity, please choose from the primary and expanded palette.

While it is not required to use a primary palette color, it is recommended to maintain brand recognition throughout subbrands.

Example Palette 1



Example Palette 2



You may use up to all four colors in the secondary palette, but please do not exceed five colors overall in identity development.

Example Palette 3



Example Palette 1



If you are using one or more accent color (up to three), please use at least one color from the primary or secondary palette.

Example Palette 2



Do not use a color from the accent palette as the dominant color in the application.

Example Palette 3





ALLIED ORGANIZATIONS AND CO-BRANDING

EXISTING ALLIED ORGANIZATIONS

It is recognized that there are several organizations that are closely aligned with the City and County of Denver, which each have their own brand personality. Examples of these organizations include the Denver Zoo, the Denver Botanic Gardens, Denver Water, and Denver Public Schools. These organizations are not required to rebrand to align with the new branding standards.

DENVER BOTANIC
GARDENS

x



.75 x

ALLIED ORGANIZATION CO-BRANDING WITH THE CITY OF DENVER

Allied organizations with their own brand personality are not required to include the City and County of Denver logo on their collateral. However, if they decide to do so and have met the requirements outline on page 1, the City and County of Denver logo usage must comply with this guide and it must visually be at least 75% of the allied organization's logo. Additionally, please do not lockup the allied organization and City and County of Denver's logo, or use parts of the Denver logo within the allied organization's logo. Maintain clear space defined on **page 3**.



DENVER BOTANIC
GARDENS



(Maintain clear area defined on p. 3)

CO-BRANDING PARTNERING AGENCIES AND SPONSORS

The City and County of Denver often partners with outside entities to promote a program or service. When partnering with outside organizations it is acceptable, if granted permission by both entities, to place their logos side by side with the Denver D.



GLOSSARY OF TERMS

Accent Color — A palette chosen to accent or support main colors utilized in identity development.

Clear Zone — Logo guidelines often specify a clear zone surrounding the logo. No other art or type should encroach on the clear zone.

Co-Branding — If two logos appear together to imply a cooperative effort, it is called co-branding. Logos used in co-branding should always respect the necessary clear space surrounding each logo.

Digital File — Digital files that are prepared by graphic designers to be printed or to be uploaded to web sites.

Foreground — The visual plane in an image closest to the viewer.

Four-Color Process — Process printing uses four inks (cyan, magenta, yellow and black — also referred to as CMYK) printed together to create a wide spectrum of colors.

Graphic Standards — An organization's requirements for reproducing its graphics and branding elements on all surfaces.

Glyph Icons — A graphic symbol that provides the appearance or form for a character. A glyph can be an alphabetic or numeric font or some other symbol that pictures an encoded character.

Hex Colors — Hexadecimal numbers or "hex" numbers are a base-16 numbering system used to define colors on web pages. A hex number is written from 0-9 and then A-F.

Lockup — The final form of a logo and a icon with all of the elements locked in their relative positions. For the sake of maintaining consistency in all mediums and to create a sense of cohesion between the elements, the lockup should not be taken apart or altered in any way.

Logotype — Logotype refers specifically to a word integrated into the logo.

Mobile Application — Also known as an app, a mobile application is a term used to describe software that runs on smart phones and mobile phones.

Monochromatic — Containing or using only one color.

Navigation — A user interface element within a webpage that contains links to other sections of the website.

Pixels — A physical point in a raster image, or the smallest addressable element in a display device; so it is the smallest controllable element of a picture represented on the screen.

Primary Icon — An organization's predominant mark; the preferred logo to be used on collateral.

Primary Palette — The main colors that comprise an organization's identity.

Raster Image — In computer graphics, a raster image, or bitmap, is a dot matrix data structure representing a generally rectangular grid of pixels, or points of color, viewable via a monitor, paper, or other display medium. Raster images are stored in image files with varying formats.

Re-Typeset — To re-typeset essentially means to re-type. It is never acceptable to re-type the words in a logo or tag line; instead always use the artwork provided.

Reverse Logo — A reverse logo is used when a logo appears on a dark background color that doesn't provide enough contrast. In order to make the logo more legible, the logo colors are changed to white.

RGB Format — Colors are used in RGB (red, green and blue) format when they appear on computer or television screens.

Scalable — An icon or logo's ability to be reduced or blown up in size.

Secondary Palette — Colors chosen to support the primary palette in an organization's identity.



GLOSSARY OF TERMS CONTINUED

Splash Screen — An image that appears while a computer program is loading. It may also be used to describe an introduction page on a website.

Spot Color — Spot color printing uses pre-mixed ink colors determined by the Pantone Matching System (PMS). They accurately represent color chips provided to the print and design industry.

Tagline — Tagline refers to a few word description that often accompanies a logo to make it more descriptive.

Tonal Contrast — The difference between the light and dark areas in a composition.

Typeface — Typeface is the same as “font.” A font or typeface is a professionally designed alphabet. Most logo guidelines specify the typeface to use with the logo.

Typesetting — Before computers became a part of design and printing, words were prepared for print by manually setting individual letters in the right sequence: “typesetting.” The term is still used to describe preparation of letters and words for print. If you choose a font and letter size for placement in a document, you are “typesetting.”

Vector — An image made up of solids, lines and curves that can be scaled or edited without affecting image resolution.

Web-Safe Font — A set of fonts that appear on a large percentage of computers. Common Web-safe fonts include: Arial, Courier New, Times New Roman, Georgia, Trebuchet, and Verdana.