KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2013

LARGE GROUP

GROUP AGREEMENT

City and County of Denver

GROUP AGREEMENT

INTRODUCTION

This Group Agreement (*"Agreement"*), including the Rate Sheet(s), the Evidence of Coverage (*"EOC"*) brochure(s) the Group Application form, and the Performance Guarantees document, all of which are incorporated into this *Agreement* by reference, and any amendments to any of them, 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 *Evidence of Coverage.* If Group does not renew this *Agreement*, Group must give Health Plan written notice as described in the "Termination of *Agreement*" Section.

TERM OF *AGREEMENT* and RENEWAL

Term of Agreement

This *Agreement* is effective for the term shown on the Rate Sheet, 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, 2009 (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, 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 Permanent 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 Permanent 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 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 large group market as permitted by law. If Health Plan discontinues offering a particular product in the 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 to groups in the large group market. If Health Plan discontinues offering all products to groups in the large 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 for the benefit of Members, 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. 10-16-105.3, 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 consents 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. In no case will Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

- 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 and the ratio between the number of Members and the total number of people who are eligible to enroll as Members will not drop by 20 percent or more (based upon all subscribers for all of Kaiser's plans). For the purpose of computing this percentage requirement, Group may include members and those eligible to enroll as members under all other agreements between Group and Health Plan and all other Kaiser Foundation Health Plans and Group Health Cooperative.
    - 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.

- 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 and County of Denver ("City"), State of Colorado law, or federal law.

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.*

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

Assignment

Health Plan may not assign, transfer, pledge, or hypothecate in any way this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. Notwithstanding the foregoing, if Health Plan assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this *Agreement* will continue in full force and effect as if such corporation, firm or person were a party to this *Agreement*, provided that such corporation, firm or person continues to provide prepaid health services. No duties imposed by this *Agreement* 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] [or] [Kaiser Permanente Medicare Cost] 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 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 9.1.2. (C) 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 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:

Director of Benefits
Denver Career Service
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, Colorado 80014-1622

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 "recission" 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 (presently $150,000 per person, $600,000 per occurrence) 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 **Fifty Seven Million Dollars ($57,000,000.00)** unless additional appropriation is made by Group and this *Agreement* is amended by the parties pursuant to the **AMENDMENT OF *AGREEMENT*** section of this *Agreement*. If Group fails to pay 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.

Arbitration: Disputes Between Health Plan and the Group.

All disputes between the City and Health Plan or Group and Health Plan, other than tort claims, shall be resolved by binding arbitration before the Commercial Arbitration Rules of the American Arbitration Association to the extent permitted by Colorado law and by the Colorado Uniform Arbitration Act, unless both parties agree in writing to use another form of alternative dispute resolution (e.g., mediation). The parties will seek to mutually agree on the appointment of an arbitrator, consistent with Colorado law. Arbitration hearings will be held at the neutral administrator's offices in Denver, Colorado, or at another location agreed upon in writing by the parties. The results of the binding arbitration shall be final, and no further recourse in a court of law or otherwise will be available to either Health Plan or the Group or City, except as otherwise provided by the Colorado Uniform Arbitration Act. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. Judgment upon the award rendered by the arbitrator(s) shall be entered into any court having jurisdiction. The parties shall equally share the costs of arbitration; however, each party shall be individually responsible for the expenses related to its attorney, experts and evidence.

Dated: _____

CITY AND COUNTY OF DENVER

By: _____

_____,Executive Director

Career Service Authority

APPROVED AS TO FORM:

_____, Attorney

City and County of Denver

By: _____

Robert A. McDermott, Esq.
Sr. Assistant City Attorney

KAISER FOUNDATION HEALTH PLAN

OF COLORADO

By: Donna Lynne

Donna Lynne, President

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_____

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2013

LARGE GROUP

GROUP AGREEMENT

City and County of Denver

GROUP AGREEMENT

INTRODUCTION

This Group Agreement ("*Agreement"*), including the Rate Sheet(s), the Evidence of Coverage (*"EOC"*) brochure(s) the Group Application form, and the Performance Guarantees document, all of which are incorporated into this *Agreement* by reference, and any amendments to any of them, 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 *Evidence of Coverage.* If Group does not renew this *Agreement*, Group must give Health Plan written notice as described in the "Termination of *Agreement*" Section.

TERM OF *AGREEMENT* and RENEWAL

Term of Agreement

This *Agreement* is effective for the term shown on the Rate Sheet, 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, 2009 (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, 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

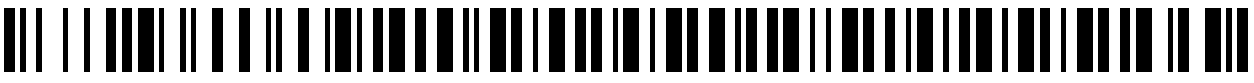
If Group has Kaiser Permanent Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month 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 Permanent 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 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 large group market as permitted by law. If Health Plan discontinues offering a particular product in the 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 to groups in the large group market. If Health Plan discontinues offering all products to groups in the large 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 for the benefit of Members, 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. 10-16-105.3, 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 consents 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. In no case will Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

- 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 and the ratio between the number of Members and the total number of people who are eligible to enroll as Members will not drop by 20 percent or more (based upon all subscribers for all of Kaiser's plans). For the purpose of computing this percentage requirement, Group may include members and those eligible to enroll as members under all other agreements between Group and Health Plan and all other Kaiser Foundation Health Plans and Group Health Cooperative.

    - 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.

- 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 and County of Denver ("City"), State of Colorado law, or federal law.

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.*

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

Assignment

Health Plan may not assign, transfer, pledge, or hypothecate in any way this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. Notwithstanding the foregoing, if Health Plan assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this *Agreement* will continue in full force and effect as if such corporation, firm or person were a party to this *Agreement*, provided that such corporation, firm or person continues to provide prepaid health services. No duties imposed by this *Agreement* 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] [or] [Kaiser Permanente Medicare Cost] 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 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 9.1.2. (C) 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 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.

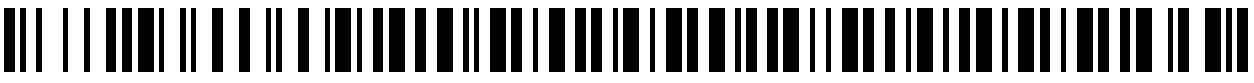
Health Plan agrees that it will keep and preserve for at least six (6) years after the final payment under this *Agreement* all directly pertinent books, documents, papers and records of Health Plan involving transactions related to this *Agreement.*

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:

Director of Benefits

Denver Career Service

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, Colorado 80014-1622

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 "recission" 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 (presently $150,000 per person, $600,000 per occurrence) 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.

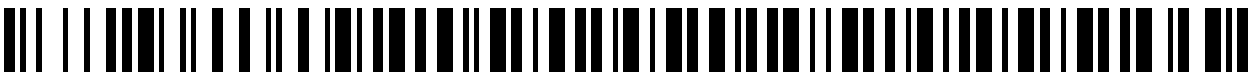
The parties understand and agree that all terms and conditions of this *Agreement*, together with the exhibits and attachments hereto, if any, any or all of which, by reasonable implication, contemplate continued performance or compliance beyond the expiration or termination of this *Agreement* (by expiration 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 **Fifty Seven Million Dollars ($57,000,000.00)** unless additional appropriation is made by Group and this *Agreement* is amended by the parties pursuant to the **AMENDMENT OF *AGREEMENT*** section of this *Agreement*. If Group fails to pay 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.

Arbitration: Disputes Between Health Plan and the Group.

All disputes between the City and Health Plan or Group and Health Plan, other than tort claims, shall be resolved by binding arbitration before the Commercial Arbitration Rules of the American Arbitration Association to the extent permitted by Colorado law and by the Colorado Uniform Arbitration Act, unless both parties agree in writing to use another form of alternative dispute resolution (e.g., mediation). The parties will seek to mutually agree on the appointment of an arbitrator, consistent with Colorado law. Arbitration hearings will be held at the neutral administrator's offices in Denver, Colorado, or at another location agreed upon in writing by the parties. The results of the binding arbitration shall be final, and no further recourse in a court of law or otherwise will be available to either Health Plan or the Group or City, except as otherwise provided by the Colorado Uniform Arbitration Act. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. Judgment upon the award rendered by the arbitrator(s) shall be entered into any court having jurisdiction. The parties shall equally share the costs of arbitration; however, each party shall be individually responsible for the expenses related to its attorney, experts and evidence.



Dated: _____

CITY AND COUNTY OF DENVER

By: _____

Nita Henry, Executive Director

Career Service Authority

APPROVED AS TO FORM:

Douglas J. Friednash, Attorney

City and County of Denver

By: _____

Robert A. McDermott, Esq.

Sr. Assistant City Attorney

KAISER FOUNDATION HEALTH PLAN

OF COLORADO

By:_____

Donna Lynne, President

2013 Large Group – Kaiser Group Agreement for the City and County of Denver

Exhibit A – Rate Sheets

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver

Group/Subgroup Number: 75-001
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is Effective: 01/01/13

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a Nonprofit Corporation, herein called "Health Plan", and the organization named above herein called "Group".

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver

Group/Subgroup Number: 75-001
Plan Number: A230

ELIGIBILITY:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible employee is a Group employee who works a fixed number of hours established by the Group, meets any other eligibility requirements as set forth in Code Section 18-321 of the Denver Revised Municipal Code ("Denver Code"), or as set forth in the corresponding provisions of any future amendment of said Section, or is an eligible employee of the Denver Employees' Retirement Plan (DERP) or is an eligible retired member of DERP who is not eligible for Medicare, and who satisfies any applicable waiting period of Group, and meets the following additional criteria: If not retired, is defined as an employee under state and federal law.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: Required regular work each week for subscribing Group: 20 hours per week or greater, except there is no work week requirement for eligible retirees.

New Hire Waiting Period: Employees and Dependents are eligible on the first day of the month which follows the employee's initial date of employment.

New Employee Coverage Effective: The first day of the month that follows the employees' initial date of employment.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not Applicable.

ADDITIONAL PROVISIONS:

Attached and amended EOC is effective January 1, 2013 (See Attached Contract Addendum to Rate Sheet)

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver

Group/Subgroup Number: 75-001
Plan Number: A230

MONTHLY RATES: The monthly payments per family unit required under this agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber and Child(ren)	$929.02
Subscriber, Spouse, &Child(ren)	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver

Group/Subgroup Number: 75-001
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EDC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

AMENDED AND RESTATED RATE SHEET EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Retirees

Group/Subgroup Number: 75-002
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is Effective: 01/01/13

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a Nonprofit Corporation, herein called "Health Plan", and the organization named above herein called "Group".

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Retirees

Group/Subgroup Number: 75-002
Plan Number: A230

ELIGIBILITY:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible employee is a Group employee who works a fixed number of hours established by the Group, meets any other eligibility requirements as set forth in Code Section 18-321 of the Denver Revised Municipal Code ("Denver Code"), or as set forth in the corresponding provisions of any future amendment of said Section, or is an eligible employee of the Denver Employees' Retirement Plan (DERP) or is an eligible retired member of DERP who is not eligible for Medicare, and who satisfies any applicable waiting period of Group, and meets the following additional criteria: If not retired, is defined as an employee under state and federal law.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: Required regular work each week for subscribing Group: 20 hours per week or greater, except there is no work week requirement for eligible retirees.

New Hire Waiting Period: Employees and Dependents are eligible on the first day of the month which follows the employee's initial date of employment.

New Employee Coverage Effective: The first day of the month that follows the employees' initial date of employment.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not Applicable.

ADDITIONAL PROVISIONS:

Attached and amended EOC is effective January 1, 2013 (See Attached Contract Addendum to Rate Sheet)

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Retirees

Group/Subgroup Number: 75-002
Plan Number: A230

MONTHLY RATES: The monthly payments per family unit required under this agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber and Child(ren)	$929.02
Subscriber, Spouse, &Child(ren)	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Retirees

Group/Subgroup Number: 75-002
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EDC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

AMENDED AND RESTATED RATE SHEET EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY Matthew Britton
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra

Group/Subgroup Number: 75-003
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is Effective: 01/01/13

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a Nonprofit Corporation, herein called "Health Plan", and the organization named above herein called "Group".

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra

Group/Subgroup Number: 75-003
Plan Number: A230

ELIGIBILITY:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible employee is a Group employee who works a fixed number of hours established by the Group, meets any other eligibility requirements as set forth in Code Section 18-321 of the Denver Revised Municipal Code ("Denver Code"), or as set forth in the corresponding provisions of any future amendment of said Section, or is an eligible employee of the Denver Employees' Retirement Plan (DERP) or is an eligible retired member of DERP who is not eligible for Medicare, and who satisfies any applicable waiting period of Group, and meets the following additional criteria: If not retired, is defined as an employee under state and federal law.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: Required regular work each week for subscribing Group: 20 hours per week or greater, except there is no work week requirement for eligible retirees.

New Hire Waiting Period: Employees and Dependents are eligible on the first day of the month which follows the employee's initial date of employment.

New Employee Coverage Effective: The first day of the month that follows the employees' initial date of employment.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not Applicable.

ADDITIONAL PROVISIONS:

Attached and amended EOC is effective January 1, 2013 (See Attached Contract Addendum to Rate Sheet)

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra

Group/Subgroup Number: 75-003
Plan Number: A230

MONTHLY RATES: The monthly payments per family unit required under this agreement are, effective January 1, 2013:

1. BASIC RATES:

	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber and Child(ren)	$929.02
Subscriber, Spouse, &Child(ren)	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra

Group/Subgroup Number: 75-003
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EDC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

AMENDED AND RESTATED RATE SHEET EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013
GROUP City & County of Denver
BY Heather Brilton
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

00075.003

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-007
Subgroup Name: City and County of Denver-Retirees - COS **Plan Number:** A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-007
Subgroup Name: City and County of Denver- Retirees - COS **Plan Number:** A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-007
Subgroup Name: City and County of Denver- Retirees - COS **Plan Number:** A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
Family (Subscriber, Spouse, & Child(ren))	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-007
Subgroup Name: City and County of Denver- Retirees - COS **Plan Number:** A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013
GROUP City + County of Denver
BY Heather Butler
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

00075.007

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver - COS

Group/Subgroup Number: 75-008
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-COS

Group/Subgroup Number: 75-008
Plan Number: A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-COS

Group/Subgroup Number: 75-008
Plan Number: A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:

	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
Family (Subscriber, Spouse, & Child(ren))	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-COS

Group/Subgroup Number: 75-008
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

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JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City + County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra COS

Group/Subgroup Number: 75-009
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra COS

Group/Subgroup Number: 75-009
Plan Number: A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra COS

Group/Subgroup Number: 75-009
Plan Number: A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
Family (Subscriber, Spouse, & Child(ren))	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra COS

Group/Subgroup Number: 75-009
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City + County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- PB

Group/Subgroup Number: 75-010
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

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AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- PB

Group/Subgroup Number: 75-010
Plan Number: A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- PB

Group/Subgroup Number: 75-010
Plan Number: A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:

	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
Family (Subscriber, Spouse, & Child(ren))	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- PB

Group/Subgroup Number: 75-010
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retirees - PB

Group/Subgroup Number: 75-011
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-011
Subgroup Name: City and County of Denver- Retirees - PB **Plan Number:** A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

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Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-011
Subgroup Name: City and County of Denver- Retirees - PB **Plan Number:** A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
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Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
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A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-011
Subgroup Name: City and County of Denver- Retirees - PB **Plan Number:** A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY Heather Brown
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-012
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-012
Plan Number: A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-012
Plan Number: A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
Family (Subscriber, Spouse, & Child(ren))	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-012
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver – DERP - NC

Group/Subgroup Number: 75-029
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is Effective: 01/01/13

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a Nonprofit Corporation, herein called "Health Plan", and the organization named above herein called "Group".

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver – DERP - NC

Group/Subgroup Number: 75-029
Plan Number: A230

ELIGIBILITY:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible employee is a Group employee who works a fixed number of hours established by the Group, meets any other eligibility requirements as set forth in Code Section 18-321 of the Denver Revised Municipal Code ("Denver Code"), or as set forth in the corresponding provisions of any future amendment of said Section, or is an eligible employee of the Denver Employees' Retirement Plan (DERP) or is an eligible retired member of DERP who is not eligible for Medicare, and who satisfies any applicable waiting period of Group, and meets the following additional criteria: If not retired, is defined as an employee under state and federal law.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: Required regular work each week for subscribing Group: 20 hours per week or greater, except there is no work week requirement for eligible retirees.

New Hire Waiting Period: Employees and Dependents are eligible on the first day of the month which follows the employee's initial date of employment.

New Employee Coverage Effective: The first day of the month that follows the employees' initial date of employment.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not Applicable.

ADDITIONAL PROVISIONS:

Attached and amended EOC is effective January 1, 2013 (See Attached Contract Addendum to Rate Sheet)

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver – DERP - NC

Group/Subgroup Number: 75-029
Plan Number: A230

MONTHLY RATES: The monthly payments per family unit required under this agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber and Child(ren)	$929.02
Subscriber, Spouse, &Child(ren)	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver – DERP - NC

Group/Subgroup Number: 75-029
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EDC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

AMENDED AND RESTATED RATE SHEET EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY _____
AUTHORIZED REPRESENTATIVE

January 17, 2013

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-039
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-039
Plan Number: A230

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-039
Plan Number: A230

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:

	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber & Child(ren)	$929.02
Family (Subscriber, Spouse, & Child(ren))	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-039
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013
GROUP City & County of Denver
BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra - NC

Group/Subgroup Number: 75-049
Plan Number: A230

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is Effective: 01/01/13

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a Nonprofit Corporation, herein called "Health Plan", and the organization named above herein called "Group".

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra - NC

Group/Subgroup Number: 75-049
Plan Number: A230

ELIGIBILITY:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible employee is a Group employee who works a fixed number of hours established by the Group, meets any other eligibility requirements as set forth in Code Section 18-321 of the Denver Revised Municipal Code ("Denver Code"), or as set forth in the corresponding provisions of any future amendment of said Section, or is an eligible employee of the Denver Employees' Retirement Plan (DERP) or is an eligible retired member of DERP who is not eligible for Medicare, and who satisfies any applicable waiting period of Group, and meets the following additional criteria: If not retired, is defined as an employee under state and federal law.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: Required regular work each week for subscribing Group: 20 hours per week or greater, except there is no work week requirement for eligible retirees.

New Hire Waiting Period: Employees and Dependents are eligible on the first day of the month which follows the employee's initial date of employment.

New Employee Coverage Effective: The first day of the month that follows the employees' initial date of employment.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not Applicable.

ADDITIONAL PROVISIONS:

Attached and amended EOC is effective January 1, 2013 (See Attached Contract Addendum to Rate Sheet)

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra - NC

Group/Subgroup Number: 75-049
Plan Number: A230

MONTHLY RATES: The monthly payments per family unit required under this agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$464.51
Subscriber & Spouse	$1021.92
Subscriber and Child(ren)	$929.02
Subscriber, Spouse, &Child(ren)	$1486.43

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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HEALTH PLAN OF COLORADO
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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver-Cobra - NC

Group/Subgroup Number: 75-049
Plan Number: A230

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EDC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

AMENDED AND RESTATED RATE SHEET EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 13

GROUP City and County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives

Group/Subgroup Number: 75-020
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives

Group/Subgroup Number: 75-020
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives

Group/Subgroup Number: 75-020
Plan Number: 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives

Group/Subgroup Number: 75-020
Plan Number: 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013
GROUP City & County of Denver
BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra

Group/Subgroup Number: 75-021
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra

Group/Subgroup Number: 75-021
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra

Group/Subgroup Number: 75-021
Plan Number: 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra

Group/Subgroup Number: 75-021
Plan Number: 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree

Group/Subgroup Number: 75-022
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree

Group/Subgroup Number: 75-022
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree

Group/Subgroup Number: 75-022
Plan Number: 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree

Group/Subgroup Number: 75-022
Plan Number: 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City and County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-023
Subgroup Name: City and County of Denver- Active - COS **Plan Number:** 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-023
Subgroup Name: City and County of Denver- Active - COS **Plan Number:** 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-023
Subgroup Name: City and County of Denver- Active - COS **Plan Number:** 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

KAISER PERMANENTE®

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-023
Subgroup Name: City and County of Denver- Active - COS **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City + County of Denver

BY Heather Brito
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-024
Subgroup Name: City and County of Denver- Cobra - COS **Plan Number:** 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-024
Subgroup Name: City and County of Denver- Cobra - COS **Plan Number:** 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-024
Subgroup Name: City and County of Denver- Cobra - COS **Plan Number:** 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-024
Subgroup Name: City and County of Denver- Cobra - COS **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-025
Subgroup Name: City and County of Denver- Retiree - COS **Plan Number:** 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-025
Subgroup Name: City and County of Denver- Retiree - COS **Plan Number:** 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

KAISER PERMANENTE®

KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-025
Subgroup Name: City and County of Denver- Retiree - COS **Plan Number:** 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-025
Subgroup Name: City and County of Denver- Retiree - COS **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City and County of Denver

BY _____
GROUP REPRESENTATIVE

BY _____
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Active - PB

Group/Subgroup Number: 75-026
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Active - PB

Group/Subgroup Number: 75-026
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Active - PB

Group/Subgroup Number: 75-026
Plan Number: 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-026
Subgroup Name: City and County of Denver- Active - PB **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-027
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-027
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-027
Plan Number: 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - PB

Group/Subgroup Number: 75-027
Plan Number: 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree - PB

Group/Subgroup Number: 75-028
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree - PB

Group/Subgroup Number: 75-028
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-028
Subgroup Name: City and County of Denver- Retiree - PB **Plan Number:** 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:

	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-028
Subgroup Name: City and County of Denver- Retiree - PB **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City + County of Denver

BY Heather Brito
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree - NC

Group/Subgroup Number: 75-030
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree - NC

Group/Subgroup Number: 75-030
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-030
Subgroup Name: City and County of Denver- Retiree - NC **Plan Number:** 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Retiree - NC

Group/Subgroup Number: 75-030
Plan Number: 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-031
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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A NONPROFIT CORPORATION

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GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-031
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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KAISER FOUNDATION
HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Actives - NC

Group/Subgroup Number: 75-031
Plan Number: 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
Subscriber & Child(ren)	$759.43
Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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A NONPROFIT CORPORATION

AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-031
Subgroup Name: City and County of Denver- Actives - NC **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE 1/17, 2013

GROUP City + County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

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HEALTH PLAN OF COLORADO
A NONPROFIT CORPORATION

AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - NC

Group/Subgroup Number: 75-032
Plan Number: 620A

OPEN ENROLLMENT PERIODS:

From: 10/01 Through: 11/15, Amended and Restated Group Agreement Rate Sheet ("Rate Sheet") is effective: 01/01/13.

INTRODUCTION:

This Agreement, consisting of the Group Agreement and Evidence of Coverage (EOC), as supplemented by this rate sheet, has been entered into between Kaiser Foundation Health Plan of Colorado, a nonprofit corporation, herein called "Health Plan", and the organization named above herein called "Group."

Health Plan, in consideration of the monthly payments to be paid to Health Plan by Group and in consideration of the Copayments to be paid by or on behalf of Members, agrees to arrange necessary medical and hospital services and other benefits as specified in the EOC for eligible persons who enroll hereunder, in accord with the terms, conditions, limitations and exclusions of that Agreement.

TERM OF AGREEMENT:

This Agreement is effective from January 01, 2013 through December 31, 2013, unless terminated as set forth in the "Termination of Agreement" section in the Group Agreement. This Agreement does not automatically renew. Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section in the Group Agreement, or offer Group a new Agreement to become effective immediately after termination of this Agreement. Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m., on the termination date.

AMENDMENT PROCEDURE:

Amendments to this Agreement may only be made as provided in and consistent with the Group Agreement.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver
Subgroup Name: City and County of Denver- Cobra - NC

Group/Subgroup Number: 75-032
Plan Number: 620A

ELIGIBILITY:

CITY AND COUNTY OF DENVER:

Members must meet the following requirements in addition to those specified in the EOC:

An eligible Member is a Group employee who is a classified member of the City and County of Denver (Group), or retired classified member of Group who is under age 65 and who is not eligible for Medicare ("Retiree"), meets any other eligibility requirements of the Group and, if not retired, is defined as an employee under state and federal law, and a) active employees must live or work in the Service Area, inactive employees must live in the Service Area; b) retirees who select the HMO must live in the Service Area; and c) retirees who live out of the Service Area are only eligible for the Out-Of-Network option.

The following conditions of employment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the Evidence of Coverage (EOC) brochure, effective January 1, 2013. To the extent that any of the following conditions contradict those stated in the EOC, the following shall prevail:

Eligibility Rules: No New Hire Waiting Period.

New Employee Coverage Effective: Coverage is Immediate.

CITY AND COUNTY OF DENVER – SENIOR ADVANTAGE:

Not applicable.

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AMENDED AND RESTATED

GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-032
Subgroup Name: City and County of Denver- Cobra - NC **Plan Number:** 620A

ADDITIONAL PROVISIONS:

See attached contract addendum to rate sheet.

MONTHLY RATES: The monthly payments per family unit required under this Agreement are, effective January 1, 2013:

1. BASIC RATES:

	TOTAL
Subscriber Only	$379.72
Subscriber & Spouse	$835.37
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Family (Subscriber, Spouse, & Child(ren))	$1215.09

NOTE: Employees and their Spouses age 65 and over who are entitled to Medicare Benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as Members under age 65 who are not entitled to Medicare.

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AMENDED AND RESTATED
GROUP AGREEMENT RATE SHEET

Group Name: City and County of Denver **Group/Subgroup Number:** 75-032
Subgroup Name: City and County of Denver- Cobra - NC **Plan Number:** 620A

I acknowledge that, except for small claims court cases, claims subject to a Medicare Appeals procedure as applicable to Kaiser Permanente Senior Advantage Members, and benefit claims under Section 502 (a)(1)(B) of the Employee Retirement Income Security Act (ERISA), any claim asserted for alleged violation of any duty to a Member arising out of this Agreement, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this agreement, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as to Group itself to the extent permitted by the Group Agreement, and as to Group, Subscribers, Spouses, and Dependents, except as applicable law provides for judicial review of arbitration proceedings. I understand that Members enrolled under this Agreement thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the EOC. Benefit claims under Section 502 (a)(1)(B) of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor Regulation prohibiting binding arbitration of this category of claim (29 CFR SECTION 2560.503-1(c)(4)) is modified, amended, repealed, superseded or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without the need for further notice.

THIS AMENDED AND RESTATED RATE SHEET IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2013
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE January 17, 2013

GROUP City & County of Denver

BY _____
GROUP REPRESENTATIVE

BY Donna Lynne
AUTHORIZED REPRESENTATIVE

January 17, 2013

PLEASE RETURN A SIGNED COPY OF THIS RATE SHEET TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

2013 Large Group – Kaiser Group Agreement for the City and County of Denver

Exhibit B – Evidence of Coverage (HMO)

Important Benefit Information Enclosed

Evidence of Coverage

kp.org

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DIRECTORY

This Directory cross-references the standardized section names required by 3 CCR 702-4, Regulation 4-2-34 (Concerning Section Names and the Placement of those Sections in Policy Forms by Health Carriers) with those used in this Evidence of Coverage.

1. **Schedule of Benefits (Who Pays What)**

   See ***"Summary Chart"***

2. **Title Page (Cover Page)**

   No corresponding section name

3. **Contact Us**

   See ***"Contact Us"***

4. **Table of Contents**

   See ***"Table of Contents"***

5. **Eligibility**

   See ***"Eligibility and Enrollment"*** and ***"Additional Provisions"***

6. **How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)**

   See ***"How to Obtain Services"***

7. **Benefits/Coverage (What is Covered)**

   See ***"Benefits"*** and ***"Additional Provisions"***

8. **Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)**

   See ***"Exclusions, Limitations and Reductions"***

9. **Member Payment Responsibility**

   See ***"Summary Chart"*** and ***"Miscellaneous Provisions"***

10. **Claims Procedure (How to File a Claim)**

    See ***"Internal Claims and Appeals Procedure and External Review"*** and ***"Member Satisfaction Procedure"***

11. **General Policy Provisions**

    See ***"Miscellaneous Provisions"*** and ***"Appendix"***

12. **Terminations/Nonrenewal/Continuation**

    See ***"Termination of Membership"***

13. Appeals and Complaints

See ***"Internal Claims and Appeals Procedure and External Review"*** and ***"Member Satisfaction Procedure"***

14. Information on Policy and Rate Changes

No corresponding section name

15. Definitions

See ***"Introduction"*** and ***"Definitions"***

CONTACT US

Advice Nurses	
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 call toll-free **1-800-218-1059**
TTY	*Denver/Boulder* Members: **303-338-4428** *Southern Colorado* Members: **1-866-635-7550** *Northern Colorado* Members: **1-866-635-7550** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

After-Hours Medical Needs	
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 call toll-free **1-800-218-1059**
TTY	*Denver/Boulder* Members: **303-338-4428** *Southern Colorado* Members: **1-866-635-7550** *Northern Colorado* Members: **1-866-635-7550** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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**

Binding Arbitration	
CALL	Resolve Programs **303-344-7298**

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**
TTY	**1-800-521-4874** 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**

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: **1-800-632-9700**
TTY	**1-800-521-4874** 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	www.kp.org

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: **1-800-632-9700**
TTY	**303-338-3820** or toll-free **1-800-659-2656** 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**

Transplant Administrative Offices	
CALL	**303-636-3226**
TTY	**1-800-521-4874** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

TABLE OF CONTENTS

I. INTRODUCTION

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "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 2013 contract year.

II. ELIGIBILITY AND ENROLLMENT

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, Idaho, Maryland, Ohio, 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.
   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 "Summary Chart."
   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 "Summary Chart"; 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 "Summary Chart" 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 over the dependent limiting age but under the dependent student limiting age as specified in the "Summary Chart" 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. A newborn child is automatically covered for the first 31 days.
      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 Due to Loss of Other Coverage" below.

4. Special Enrollment Due to Loss of Other Coverage
   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 the enrolling persons lose other coverage, if:

   The enrolling persons had other coverage when you previously declined all coverage through your Group (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:
   a. Exhaustion of COBRA coverage.
   b. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment, in the following situations:
      i. termination of employer contributions for non-COBRA coverage;
      ii. loss of coverage under other creditable coverage as a result of termination of employment or eligibility;
      iii. reduction in the number of hours of employment;
      iv. the involuntary termination of the creditable coverage;
      v. death of a spouse, legal separation or divorce;

vi. reaching the age limit for dependent children;
vii. Subscriber's death;
viii. a dependent is disenrolled from or otherwise becomes ineligible for Children's Basic Health Plan (application for enrollment must be made no later than 90 days after disenrollment);
ix. the enrolling person loses eligibility for Medicaid, but not due to termination for cause (application for enrollment must be made no later than 60 days after loss of coverage);
x. the individual becomes eligible to receive premium assistance under Medicaid or Children's Basic Health Plan (application for enrollment must be made no later than 60 days after eligibility determination for premium assistance);
xi. the individual has reached a lifetime maximum on all benefits;
xii. the individual has lost coverage as a result of moving out of the plan's service area.

If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined all coverage through your Group.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date your Group receives the enrollment application.

5. Special Enrollment Due to Court or Administrative Order
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents if: (a) a court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan; and (b) the request for enrollment is made within 31 days after issuance of such court order.

6. 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.

7. Kaiser Permanente Senior Advantage Limitation on Enrollment
If the Kaiser Permanente Senior Advantage plan has reached its capacity limit that the Centers for Medicare & Medicaid Services ("CMS") has approved, you may be ineligible to enroll.

8. Persons Barred From Enrolling
You cannot enroll if: (a) you have had your entitlement to receive Services through Health Plan terminated for cause; or (b) you have had your entitlement to receive Services through Health Plan terminated for failure to pay any amounts (other than Dues) owed to Health Plan or a Plan Provider as described under "Termination for Nonpayment of Any Other Charges" in the "Termination of Membership" section.

III. HOW TO OBTAIN SERVICES

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

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)," in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.
- "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.
- "Getting a Referral," in this section.

A. Your Primary Care Plan Physician

Your primary care Plan Physician (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 Plan Physician
You may select a PCP from family medicine, pediatrics, or internal medicine. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section, below.

a. ***Denver/Boulder*** Service Area
You may choose your PCP from our provider directory. If you want to receive care from a specific physician listed in the directory, please call **Member Services** to verify that the physician still participates with Health Plan and is accepting new patients. You can get a copy of the directory by calling **Member Services**. You can also get a list of Plan Physicians on our website. Go to *www.kp.org*, click on "Locate our services" then "Medical staff directory."

b. ***Southern*** and ***Northern 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*** and ***Northern Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern*** and ***Northern Colorado*** Plan Physicians.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Physician and Provider Directory for your specific Service Area. You can get a copy of the directory by calling **Member Services.** You can also get a list by visiting our website. Go to www.kp.org, click on "Locate our services" then "Medical staff directory."

If you are seeking routine or specialty care in any ***Denver/Boulder*** Plan Hospital, you must have a referral from your local PCP. If you do not get a referral, 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 after-hours or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below.

2. Changing Your Primary Care Plan Physician

a. ***Denver/Boulder*** Service Area

Please call **Member Services** to change your PCP. You may also change your physician when visiting a Plan Facility. You may change your PCP at any time.

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

Please call **Member 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. Getting a Referral

1. Referrals

a. ***Denver/Boulder*** Service Area

Medical Group physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Medical Group physician decides that you need covered Services not available from us, he or she will refer you to a non-Medical Group physician inside or outside our Service Area. You must have a written referral to the non-Medical Group physician in order for us to cover the Services. A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a non-Medical Group physician. A written or verbal recommendation by a Medical Group physician or an Affiliated Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered.

For Services in Kaiser Permanente Plan Medical Offices in the ***Southern*** and ***Northern Colorado*** Service Areas, please see "Cross Market Access," below. In order to receive Services from a Plan Facility, you must have a written referral. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Medical Group physician.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance according to Medical Group procedures. We will not pay for any care rendered or recommended by a non-Medical Group physician beyond the limits of the original referral unless the care is: (i) specifically authorized by your Medical Group physician; and (ii) approved in advance in accord with Medical Group procedures.

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

Plan Physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery and dermatology. If your Plan Physician decides that you need covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have a written referral to the non-Plan Provider in order for us to cover the Services. A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a designated non-Plan Provider. A written or verbal recommendation by a Plan Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Plan Provider.

Health Plan authorization is required for Services provided by: (i) non-Plan Providers or non-Plan Facilities; (ii) Services provided by any provider outside the ***Southern*** and ***Northern Colorado*** Service Areas; and (iii) Services performed in any facility other than the physician's office. For Services in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below. A referral for these Services will be submitted to Health Plan by the Plan Physician. Health Plan will make a determination regarding authorization for coverage.

The provider to whom you are referred will receive a notice of Health Plan's authorization by fax. You will receive a written notice of Health Plan's authorization in the mail. This notice will tell you the physician's name, address and phone number. It will also tell you the time period for which the referral is valid and the Services authorized.

2. Specialty Self-Referrals
   a. ***Denver/Boulder*** Service Area
   You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will still be required to get a written referral for laboratory or radiology Services and for specialty procedures such as a CT scan, MRI, or surgery. A written referral is also required for specialty-care visits to non-Medical Group physicians.

   b. ***Southern*** and ***Northern Colorado*** Service Areas
   You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will find the specialty-care providers eligible to receive direct referrals in the Kaiser Permanente Physician and Provider Directory for your specific Service Area. It is available on our website, www.kp.org, by clicking on "Locate our services" then "Medical staff directory." You can get a paper copy of the directory by calling **Member Services**.

   A self-referral provides coverage for routine visits only. 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 Plan Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Plan Physicians. ***Southern*** and ***Northern Colorado*** Members may be able self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access," below). Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by Kaiser Permanente before Services are rendered.

   The request for these Services can be generated by either your PCP or by a specialty-care provider. The physician or facility to whom you are referred will receive a notice of the authorization. You will receive a written notice of authorization in the mail. This notice will tell you the physician's name, address and phone number. It will also tell you the time period that the authorization is valid and the Services authorized.

3. Second Opinions
   Upon request and subject to payment of any applicable Copayments 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 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 www.kp.org, click on "Locate our services" then "Facility directory."

2. ***Southern*** and ***Northern Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that physician's office. You can find ***Southern*** and ***Northern Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Physician and Provider Directory for your specific 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 www.kp.org, click on "Locate our services" then "Facility directory."

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 and Non-Emergency, Non-Routine Care" in the "Benefits" section.

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office

hours. Your office visit Charge, as defined in the "Summary Chart", will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after-hours Plan Facilities. The Charge for non-emergency, non-routine care received in Plan Facilities after regular office hours listed in the "Summary Chart" will apply. For additional information about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.

Non-emergency, non-routine care received at a non-Plan Facility inside our Service Areas is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside our Service Areas, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized non-emergency, non-routine care outside our Service Areas. Please see "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section for coverage information about out-of-Plan non-emergency, non-routine care Services.

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 (not more than 90 days), 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 and Coinsurance described in this EOC. The 90-day limit on visiting member care does not apply to Members who attend an accredited college or vocational school.

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. Out-of-Area Student Benefit

A limited benefit is available to Dependents who are full-time students attending an accredited college, vocational or boarding school outside any Kaiser Foundation Health Plan service area. The Out-of-Area Student Benefit applies to covered Services, including prescription drugs that are covered under this EOC. We will pay 80% of Charges for covered Services. The Member is responsible for paying the remaining 20% of Charges. The benefit is limited to $1,200 per year.

To qualify for the out-of-area student benefit, the Dependent must: (1) be under the Group's Dependent age limit; and (2) carry at least 12 credit hours per term. Verification of student status will be necessary. For more information, please call **Member Services**.

Visiting member care will continue to apply to students attending an accredited college or vocational school in other Kaiser Foundation Health Plan or allied plan service areas.

Exclusions and Limitations:

1. Services received outside the United States are not covered.
2. Transplant Services are not covered.
3. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services, Non-Emergency, Non-Routine Care) are not covered under the Out-of-Area Student Benefit.
4. This benefit does not apply toward the Out-of-Pocket Maximum.

G. 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 out-of-Plan non-emergency, non-routine care). 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.

H. 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.

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 has been victimized by fraud, please call **Member Services** to report your concern.

I. Cross Market Access

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

1. ***Denver/Boulder*** Members:
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the ***Southern*** and ***Northern Colorado*** Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern*** or ***Northern Colorado*** unless authorized by Health Plan.
2. ***Southern*** and ***Northern Colorado*** Members:
   Southern and ***Northern Colorado*** Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder*** Service Area.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; after-hours 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 Service Area and at which designated Kaiser Permanente Plan Medical Offices, if applicable, you may receive Services at, please call **Member Services**.

IV. BENEFITS

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the Services are 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
- The Services are provided, prescribed, authorized or directed by a Plan Physician. 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) "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine 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) "Getting a Referral" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care").

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations and Reductions" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Summary Chart."

A. Outpatient Care

Outpatient Care for Preventive Care, Diagnosis and Treatment

We cover, under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following outpatient care 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.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by a Plan Physician.
9. Medical social Services.
10. Preventive care Services (see "Preventive Care Services" in this "Benefits" section for more details).

NOTE: To determine if your Group has the bariatric surgery benefit, see the "Summary Chart." If your group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

We cover, only as described under this "Benefits" 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 a Plan Physician determines 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. **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 his/her own Copayments, Deductibles and Coinsurance requirements.
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 "Summary Chart." 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.

C. 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.

D. 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 approved by Kaiser Permanente 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.

Mental health Services required in connection with the treatment of chemical dependency are covered as provided in the "Mental Health Services" section below.

Members who are disruptive or abusive may have their membership terminated for cause.

4. Chemical Dependency Services Exclusion: Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

E. 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 Medical Group; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover at no Charge: equipment; training; and medical supplies required for home dialysis.

F. 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**.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit

      If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies, or in the ***Southern*** and ***Northern Colorado*** Service Areas, at pharmacies designated by Health Plan. You may obtain these drugs at the Copayment or Coinsurance shown on the "Summary Chart." 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 coverage includes supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance applies for these types of drugs. For more information, please refer to the prescription drug benefit description in "Additional Provisions."

      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 "Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." If your prescription drug Copayment shown on the "Summary Chart" 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.

   c. Administered Drugs

      We cover the following administered drugs as part of your Hospital Inpatient Care and Skilled Nursing Facility benefit. 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 "Summary Chart." This Copayment or Coinsurance may be in addition to your Outpatient Care 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.

   d. 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. 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 contact **Member Services**.

e. 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 "Summary Chart."

f. Food Supplements
Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. 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.

g. 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 "Summary Chart." 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. ***Denver/Boulder*** Service Area: Compound medications are covered as long as they are on the compounding formulary.
   c. ***Southern*** and ***Northern Colorado*** Service Areas: Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.

3. 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 "Summary Chart."
   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 "Summary Chart."
   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. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
   l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. (***Denver/Boulder*** Members only).
   m. Prescription drugs necessary for Services excluded under this Evidence of Coverage.

G. 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.

Limitation: 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.

   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. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

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 prostheses 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 in newborn Members 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 accord 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."

H. Early Childhood Intervention Services

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

   Note: You may be billed as a non-Member for any EIS received after the maximum amount permitted by State law is satisfied.

2. Limitations
   The maximum amount of coverage permitted 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 Evidence of Coverage.

I. Emergency Services and Non-Emergency, Non-Routine 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," below, 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** and/or **Quality Resource Coordinator**.

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:

i. Services outside our Service Area for conditions that, before leaving the Service Area, you knew or should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery performed by Plan Physicians, full-term delivery and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

ii. 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 or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other

transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

2. Non-Emergency, Non-Routine Care
   a. Non-Emergency, Non-Routine Care Provided by Plan Providers
      i. ***Denver/Boulder*** Service Area

      Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities **during** regular office hours. If you need non-emergency, non-routine care during office hours and you are a Member in the ***Denver/Boulder*** Service Area, you can visit one of our Plan Facilities.

      Non-emergency, non-routine care needed **after hours**, that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services**.

      During regular office hours, please call **Advice Nurse** 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.

      After office hours, please call **After-Hours Medical Needs** for a recorded message about your options and/or to speak with the answering service who will redirect your call, 24 hours a day, 7 days a week.

      ii. ***Southern*** and ***Northern Colorado*** Service Areas

      Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities during regular office hours. If you are a ***Southern*** or ***Northern Colorado*** Member and need non-emergency, non-routine care during regular office hours, please call your Plan Physician's office.

      Non-emergency, non-routine care needed **after hours**, that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, www.kp.org, for information on designated after-hours facilities.

      After office hours, please call your Plan Physician or go to the provider directory or to our website, www.kp.org, for information on our designated after-hours facilities. You may also call the nurse advice line at the telephone number listed in your provider directory or our website, www.kp.org.

   b. Out-of-Plan Non-Emergency, Non-Routine Care

      There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside our Service Area. Non-emergency, non-routine care received from non-Plan Providers is covered only when obtained outside our Service Area, 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.

3. Payment
   a. Health Plan's payment for covered out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services 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 accord 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.

   b. Our payment is reduced by:
      i. the Copayment and/or Coinsurance for Emergency Services and Special Procedures performed in the emergency room. The emergency room and Special Procedures Copayment, 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. any other payments you would have had to make if you received the same Services from our Plan Providers; and

v. 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
vi. amounts you or your legal representative recovers from motor vehicle insurance or because of third party liability.

Note: The procedure for receiving reimbursement for out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is described in the "Internal Claims and Appeals Procedure and External Review" section, below.

J. Family Planning Services

We cover the following:

1. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control; and
2. Tubal ligations; and
3. Vasectomies; and
4. Voluntary termination of pregnancy.

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

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

K. Health Education Services

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

L. Hearing Services

1. Persons Under the Age of 18 Years

   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 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. Persons Age 18 Years and Older
   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

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

M. Home Health Care

1. Coverage

   We cover skilled nursing care, home health aide Services and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only if you are confined to your home; 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. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by Health Plan on a case-by-case basis.

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

3. Special Services Program
   If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). This Program allows you to receive up to 15 home health visits per lifetime. These visits are without Charge until you elect hospice care coverage. Coverage of hospice care is described below.

   This Program gives 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 this Program and regular 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.

N. 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 accord with our drug formulary guidelines.
h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
i. Counseling and bereavement Services.
j. Services of volunteers.

O. Infertility Services

1. Coverage
   We cover the following Services, including X-ray and laboratory procedures: (a) Services for diagnosis and treatment of involuntary infertility; and (b) artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage.

   Note: Drugs, supplies and supplements are not covered under this section. See "Drugs, Supplies and Supplements" to find out if any drugs for the treatment of infertility are covered.

2. Infertility Services Exclusions:
   a. Services to reverse voluntary, surgically induced infertility.
   b. All Services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

NOTE: To determine if your Group has the infertility benefit, see the "Summary Chart."

P. 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.

   a. Outpatient Therapy
      We cover: diagnostic evaluation; individual therapy; psychiatric treatment; 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.

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

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 a Plan Physician determines such evaluation to be 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. Please refer to "Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services" for coverage of autism spectrum disorders.
c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.
d. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
e. Services which are custodial or residential in nature.

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

1. Coverage
a. Hospital Inpatient Care, Care in a Skilled Nursing Facility and Home Health Care
We cover physical, occupational and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period.

b. Outpatient Care
We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period. See the "Summary Chart."

c. Multidisciplinary Rehabilitation Services
If, in the judgment of a Plan Physician, significant improvement in function is achievable within a two-month period, we will cover treatment for up to two (2) months per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We cover multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility.

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. Clinical criteria are used to determine appropriate candidacy for the program, which consists of: an initial evaluation; up to six (6) education sessions; up to twelve exercise sessions; and a final evaluation to be completed within a two to three-month period. See the "Summary Chart."

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 year for each physical, occupational and speech therapy. Such visits shall be distributed as Medically Necessary throughout the year 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 "Summary Chart."

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 children under the age of 19, we cover the following therapies for the treatment of Autism Spectrum Disorders:
i. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by a Plan Physician as Medically Necessary. See the "Summary Chart."

ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted by State law. See the "Summary Chart."

2. Limitations:
   a. Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature.
   b. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

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

R. 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.

S. Reconstructive Surgery

1. Coverage

   We cover reconstructive surgery when a Plan Physician determines 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 (port wine stains) on the face and neck of Members 18 years and younger. 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.

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.

T. Skilled Nursing Facility Care

1. Coverage

   We cover up to 100 days per year of 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-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 "Drugs, Supplies and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory and special procedures, see "X-ray, Laboratory and Special Procedures".

2. Skilled Nursing Facility Care Exclusion: Custodial Care, as defined in "Exclusions" under "Exclusions, Limitations and Reductions", below.

U. 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 shown on the "Summary Chart."

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 accord 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 "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

V. Vision Services

1. Coverage

We cover wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. 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."

W. X-ray, Laboratory and Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray and laboratory tests, Services and materials, including isotopes, electrocardiograms, electroencephalograms and mammograms.
      ii. Therapeutic X-ray Services and materials.
      iii. Special procedures such as MRI, CT, PET and nuclear medicine. **Note:** Members will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. The Member is responsible for any applicable Copayment or Coinsurance for Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.
   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 without Charge.

2. X-ray, Laboratory and 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.

V. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

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" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services:
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and Services of chiropractors.
   See the "Summary Chart."

2. **Certain Exams and Services.** Physical examinations 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 major improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits" 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 for newborn Members 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 Hospital, Plan Facility or Skilled Nursing Facility.

The following Services for TMJ may be covered if a Plan Physician determines they are 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;
   b. Ace-type bandages; and
   f. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits" 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.

10. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.

11. **Intermediate Care.** Care in an intermediate care facility.

12. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

13. **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 out-of-Plan non-emergency, non-routine care.

14. **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.

15. **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.

16. **Transgender Identity Disorder**. Services related to transgender identity disorder and sexual reassignment, including but not limited to, hormone therapy, surgery and psychosocial assessments for surgery.

17. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines 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 under "Getting a Referral" in the "How to Obtain Services" section. Travel and lodging expenses are not covered for Members who are referred to a non-Plan Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

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 of the National Association of Insurance Commissioners. Those guidelines are part of this EOC. For Members entitled to Medicare, Medicare is the primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and Medicare coverage be secondary. The COB guidelines determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this EOC is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during the year to pay for your out-of-pocket expenses for Services that are partially covered by either us or your other coverage. If you are entitled to a Benefit Reserve Account, we will give you information about this account.

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 reimburse us 100% of Charges 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.

If you are involved in an automobile-related accident, please contact **Patient Financial Services** right away so that we can coordinate benefits with the automobile insurance carrier and determine whether we or the automobile insurance carrier has primary coverage. 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, but we will be subrogated only to the extent of the total Charges for the relevant Services.

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. The proceeds of any judgment or settlement that you, your attorney or your representative get shall first be applied to fully satisfy our lien, even if the total amount of your recovery from all sources is less than the actual or estimated losses and damages you incurred, and without regard for how the proceeds are characterized or itemized. We deny any application of the Made Whole doctrine.

We will not be responsible for any fees you incur to obtain any judgment or settlement. Costs we incur will be borne by us. Costs of your representation will be borne by you. We deny any application of the Common Fund doctrine. 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 any other party, you must send written notice of the claim or legal action to **Patient Financial Services**. 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, 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.

Note: For recoveries on or after August 11, 2010, reimbursement for benefits will be governed by state law.

3. Surrogacy

In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement of Charges for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, up to the monetary amount you receive to act as a surrogate. 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.

VI. INTERNAL CLAIMS AND APPEALS PROCEDURE AND EXTERNAL REVIEW

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 "Internal Claims and Appeals Procedures and External Review" 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,

b. terminate your membership retroactively except as the result of non-payment of premiums (also known as rescission), 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.

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

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described below in this "Internal Claims and Appeal Procedures and External Review" section.

Language and Translation Assistance

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then your notice of adverse benefit determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with your claim and/or appeal by calling **Member Services**. We offer language assistance by calling **Member Services**.

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

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then you may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling **Member Services**.

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
(3030) 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

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

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; (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 claim be treated as urgent.

      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. 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 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 wend you written confirmation within 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. In addition, you may also tell us 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 must either mail or fax your appeal 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 "Claims and Appeals Procedures" 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 you 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 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 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 the **Appeals Program**.

Unless you are appealing an urgent care claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you 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 you will have to pay for the Services that we decide are not covered.

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 the **Appeals Program**.

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 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. 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 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 appeal to the **Appeals Program**.

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

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

c. Urgent Concurrent Care Appeal

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

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

3. Post-Service Claims and Appeals

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

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

a. Post-Service Claim

Within 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. 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. Your 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.

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 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.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least 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 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 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 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 First Level Appeal or Voluntary Second Level Appeal decision letter, 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 medical judgment including one based on our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered service, network provider expertise or access, or our determination that the requested care or service is experimental or investigational. If our final adverse decision does not involve medical judgment, 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.

To request external review, you must 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 another copy of this form) to the **Appeals Program** within 4 months of the date of receipt of the mandatory internal appeal decision or within 60 days of receipt of our Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be 3 days after the date on which our notice was drafted, unless you can prove that you received our notice after the 3 day period ends.

If we do not receive your external review request form, 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.

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 external review criteria when you submit your request for external review along with the other required information (described, above). No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

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 appealing the denial to the Division of Insurance. At the same time that we send this 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 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 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 within 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 that the external review decision is the final appeal available under state insurance law.

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 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.

VII. MEMBER SATISFACTION PROCEDURE

A. 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 following the procedures listed below.

1. Sending your written complaint to **Member Services**; or
2. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
3. Telephoning **Member Services**.

B. After you notify us of a complaint, this is what happens:

1. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
2. The Member Services Liaison or a Plan Physician evaluates the facts and makes a recommendation for corrective action, if any.
3. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
4. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

C. 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**.

VIII. TERMINATION OF MEMBERSHIP

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 meet the eligibility requirements in Section II on the first day of a month, then become ineligible, your membership terminates on the last day of that month unless your Group has agreed to a different termination date. Please check with your Group's benefits administrator to confirm your termination date.

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 by sending written notice to the Subscriber at least 15 days before the termination date if anyone in your Family Unit commits any of the following acts:

1. 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
2. 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
3. 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
4. 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 not be allowed to convert to non-group coverage or to re-enroll in Health Plan. 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

1. Nonpayment of Dues

   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.

2. Nonpayment of Any Other Charges

   We may terminate your membership if you fail to pay any amount you owe Health Plan or to a Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. If we receive full payment before the termination date, we will not terminate your membership. Also, if we terminate your membership for nonpayment of any other Charges, we will reinstate your membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date.

   Persons whose memberships are terminated for nonpayment of any other Charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment.

E. 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 and Enrollment" 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.

NOTE: If your Dependent child ceases to qualify as an eligible Dependent under Health Plan, such as reaching the age constraints, he/she may elect to convert to a non-group plan on a direct pay basis (see "Eligibility and Enrollment" and "Conversion of Membership" for more details).

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.

F. Conversion of Membership

You may be eligible to convert to a non-group plan on a direct pay basis if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section or if you enroll in COBRA or USERRA continuation coverage and then lose eligibility for that COBRA or USERRA coverage. However, you may not convert to this non-group plan if:

1. You continue to be eligible for coverage through your Group; or
2. You live in another Kaiser Foundation Health Plan or allied plan service area, except that the Subscriber's or the Subscriber's spouse's otherwise eligible children are not ineligible to be covered Dependents solely because they live in another Kaiser Foundation Health Plan or allied plan service area if: (a) they are attending an accredited college or accredited vocational school; or (b) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO); or
3. Your membership ends because our Agreement with your Group terminates; or
4. We terminated your membership under "Termination for Cause" or "Nonpayment of Any Other Charges" in this "Termination of Membership" section.

You must apply to convert your membership within 31 days after your Group coverage ends. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Dues, and the benefits, Copayments and Coinsurance under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, please call **Member Services**.

G. 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. 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:

A. Performed an act, practice, or omission that constitutes fraud; or
B. 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.

X. MISCELLANEOUS PROVISIONS

A. Administration of Agreement

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

B. 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**.

C. 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.

D. 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.

E. 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.

F. Assignment

You may not assign this EOC or any of the rights, interests or obligations hereunder without our prior written consent.

G. 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.

H. 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.

I. Contracts with Plan Providers

Your 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 Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

J. Governing Law
Except as preempted by federal law, this EOC will be governed in accord 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.

K. Group and Members not Health Plan's Agents
Neither your Group nor any Member is the agent or representative of Health Plan.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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 and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers 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 of Privacy Practices* on our website at *www.kp.org*.

XI. DEFINITIONS

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

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

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).

The schedules, amounts, and payments on which Charges are based may change at any time without notice.

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 "Summary Chart."

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Summary Chart."

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 and Enrollment" 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.

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.

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."

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. 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 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, 80028, 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, 80154, 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, 80254, 80255, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80270, 80271, 80273, 80274, 80275, 80279, 80280, 80281, 80285, 80290, 80291, 80292, 80293, 80294, 80295, 80299, 80301, 80302, 80303, 80304,

80305, 80306, 80307, 80308, 80309, 80310, 80314, 80321, 80322, 80323, 80328, 80329, 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, 80513, 80514, 80516, 80520, 80530, 80533, 80534, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80601, 80602, 80603, 80614, 80621, 80623, 80640, 80642, 80643, 80651.

The ***Northern Colorado*** Service Area is that portion of Adams, Albany, Larimer, Morgan, and Weld counties within the following zip codes: 80511, 80512, 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, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82070.

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, 80940, 80941, 80942, 80943, 80944, 80945, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81013, 81014, 81015, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81246, 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 legal husband or wife.

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).

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 and Enrollment" section).

XII. APPENDIX

A. Access Plan

Colorado State 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 foreign languages.
3. Plan Physicians can also request an onsite interpreter for an appointment, procedure or Service.
4. Any interpreter assistance that we arrange or provide will be at no Charge to the Member.

C. Binding Arbitration

Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)"), which arise from any alleged failure or violation of, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

You must use Health Plan procedures to request arbitration. You can get a copy of these procedures from our **Resolve Programs** department. The arbitration hearing will be held in accord with Health Plan procedures, the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

D. 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, *www.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.

E. Women's Health and Cancer Rights Act

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

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

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2013 Large Group – Kaiser Group Agreement for the City and County of Denver

Exhibit C – Evidence of Coverage (DHMO)

Important Benefit Information Enclosed

Evidence of Coverage

kp.org

KAISER PERMANENTE®

DIRECTORY

This Directory cross-references the standardized section names required by 3 CCR 702-4, Regulation 4-2-34 (Concerning Section Names and the Placement of those Sections in Policy Forms by Health Carriers) with those used in this Evidence of Coverage.

1. **Schedule of Benefits (Who Pays What)**

   See ***"Summary Chart"***

2. **Title Page (Cover Page)**

   No corresponding section name

3. **Contact Us**

   See ***"Contact Us"***

4. **Table of Contents**

   See ***"Table of Contents"***

5. **Eligibility**

   See ***"Eligibility and Enrollment"*** and ***"Additional Provisions"***

6. **How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)**

   See ***"How to Obtain Services"***

7. **Benefits/Coverage (What is Covered)**

   See ***"Benefits"*** and ***"Additional Provisions"***

8. **Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)**

   See ***"Exclusions, Limitations and Reductions"***

9. **Member Payment Responsibility**

   See ***"Summary Chart"*** and ***"Miscellaneous Provisions"***

10. **Claims Procedure (How to File a Claim)**

    See ***"Internal Claims and Appeals Procedure and External Review"*** and ***"Member Satisfaction Procedure"***

11. **General Policy Provisions**

    See ***"Miscellaneous Provisions"*** and ***"Appendix"***

12. **Terminations/Nonrenewal/Continuation**

    See ***"Termination of Membership"***

13. Appeals and Complaints

See ***"Internal Claims and Appeals Procedure and External Review"*** and "***Member Satisfaction Procedure"***

14. Information on Policy and Rate Changes

No corresponding section name

15. Definitions

See ***"Introduction"*** and ***"Definitions"***

CONTACT US

Advice Nurses	
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 call toll-free **1-800-218-1059**
TTY	*Denver/Boulder* Members: **303-338-4428** *Southern Colorado* Members: **1-866-635-7550** *Northern Colorado* Members: **1-866-635-7550** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

After-Hours Medical Needs	
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 call toll-free **1-800-218-1059**
TTY	*Denver/Boulder* Members: **303-338-4428** *Southern Colorado* Members: **1-866-635-7550** *Northern Colorado* Members: **1-866-635-7550** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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**

Binding Arbitration	
CALL	Resolve Programs **303-344-7298**

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**
TTY	**1-800-521-4874** 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**

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: **1-800-632-9700**
TTY	**1-800-521-4874** 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	www.kp.org

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: **1-800-632-9700**
TTY	**303-338-3820** or toll-free **1-800-659-2656** 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**

Transplant Administrative Offices	
CALL	**303-636-3226**
TTY	**1-800-521-4874** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

TABLE OF CONTENTS

I. INTRODUCTION

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 "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 2013 contract year.

II. ELIGIBILITY AND ENROLLMENT

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:

   i. 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
   ii. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   iii. 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, Idaho, Maryland, Ohio, 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.
   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 "Summary Chart."
   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 "Summary Chart"; 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 "Summary Chart" 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 over the dependent limiting age but under the dependent student limiting age as specified in the "Summary Chart" 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. A newborn child is automatically covered for the first 31 days.
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 Due to Loss of Other Coverage" below.

4. Special Enrollment Due to Loss of Other Coverage
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 the enrolling persons lose other coverage, if:

The enrolling persons had other coverage when you previously declined all coverage through your Group (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:

a. Exhaustion of COBRA coverage.
b. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment, in the following situations:
   i. termination of employer contributions for non-COBRA coverage;
   ii. loss of coverage under other creditable coverage as a result of termination of employment or eligibility;
   iii. reduction in the number of hours of employment;
   iv. the involuntary termination of the creditable coverage;
   v. death of a spouse, legal separation or divorce;
   vi. reaching the age limit for dependent children;
   vii. Subscriber's death;
   viii. a dependent is disenrolled from or otherwise becomes ineligible for Children's Basic Health Plan (application for enrollment must be made no later than 90 days after disenrollment);
   ix. the enrolling person loses eligibility for Medicaid, but not due to termination for cause (application for enrollment must be made no later than 60 days after loss of coverage);

x. the individual becomes eligible to receive premium assistance under Medicaid or Children's Basic Health Plan (application for enrollment must be made no later than 60 days after eligibility determination for premium assistance);
xi. the individual has reached a lifetime maximum on all benefits; or
xii. the individual has lost coverage as a result of moving out of the plan's service area.

If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined all coverage through your Group.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date your Group receives the enrollment application.

5. Special Enrollment Due to Court or Administrative Order
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents if: (a) a court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan; and (b) the request for enrollment is made within 31 days after issuance of such court order.

6. 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.

7. Kaiser Permanente Senior Advantage Limitation on Enrollment
If the Kaiser Permanente Senior Advantage plan has reached its capacity limit that the Centers for Medicare & Medicaid Services ("CMS") has approved, you may be ineligible to enroll.

8. Persons Barred From Enrolling
You cannot enroll if: (a) you have had your entitlement to receive Services through Health Plan terminated for cause; or (b) you have had your entitlement to receive Services through Health Plan terminated for failure to pay any amounts (other than Dues) owed to Health Plan or a Plan Provider as described under "Termination for Nonpayment of Any Other Charges" in the "Termination of Membership" section.

III. HOW TO OBTAIN SERVICES

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

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)," in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.
- "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.
- "Getting a Referral," in this section.

A. Your Primary Care Plan Physician

Your primary care Plan Physician (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 Plan Physician
You may select a PCP from family medicine, pediatrics, or internal medicine. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section below.

a. ***Denver/Boulder*** Service Area
You may choose your PCP from our provider directory. If you want to receive care from a specific physician listed in the directory, please call Member Services to verify that the physician still participates with Health Plan and is accepting new patients. You can get a copy of the directory by calling **Member Services**. You can also get a list of Plan Physicians on our website. Go to *www.kp.org*, click on "Locate our services" then "Medical staff directory."

b. ***Southern*** and ***Northern 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*** and ***Northern Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern*** and ***Northern Colorado*** Plan Physicians.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Physician and Provider Directory for your specific Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list by visiting our website. Go to www.kp.org, click on "Locate our services" then "Medical staff directory."

If you are seeking routine or specialty care in any ***Denver/Boulder*** Plan Hospital, you must have a referral from your local PCP. If you do not get a referral, 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 after-hours or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access." below.

2. Changing Your Primary Care Plan Physician
   a. ***Denver/Boulder*** Service Area
   Please call **Member Services** to change your PCP. You may also change your physician when visiting a Plan Facility. You may change your PCP at any time.

   b. ***Southern*** and ***Northern Colorado*** Service Areas
   Please call **Member 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. Getting a Referral

1. Referrals
   a. ***Denver/Boulder*** Service Area
   Medical Group physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Medical Group physician decides that you need covered Services not available from us, he or she will refer you to a non-Medical Group physician inside or outside our Service Area. You must have a written referral to the non-Medical Group physician in order for us to cover the Services.

   A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a non-Medical Group physician. A written or verbal recommendation by a Medical Group physician or an Affiliated Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered.

   For Services in Kaiser Permanente Plan Medical Offices in the ***Southern*** and ***Northern Colorado*** Service Areas, please see "Cross Market Access," below. In order to receive Services from a Plan Facility, you must have a written referral. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Medical Group physician.

   A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance according to Medical Group procedures. We will not pay for any care rendered or recommended by a non-Medical Group physician beyond the limits of the original referral unless the care is: (i) specifically authorized by your Medical Group physician; and (ii) approved in advance in accord with Medical Group procedures.

   b. ***Southern*** and ***Northern Colorado*** Service Areas
   Plan Physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery and dermatology. If your Plan Physician decides that you need covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have a written referral to the non-Plan Provider in order for us to cover the Services. A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a designated non-Plan Provider. A written or verbal recommendation by a Plan Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Plan Provider.

   Health Plan authorization is required for Services provided by: (i) non-Plan Providers or non-Plan Facilities; (ii) Services provided by any provider outside the ***Southern*** and ***Northern Colorado*** Service Areas; and (iii) Services performed in any facility other than the physician's office. For Services in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below. A referral for these Services will be submitted to Health Plan by the Plan Physician. Health Plan will make a determination regarding authorization for coverage.

   The provider to whom you are referred will receive a notice of Health Plan's authorization by fax. You will receive a written notice of Health Plan's authorization in the mail. This notice will tell you the physician's name, address and phone number. It will also tell you the time period for which the referral is valid and the Services authorized.

2. Specialty Self-Referrals

a. ***Denver/Boulder*** Service Area

You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will still be required to get a written referral for laboratory or radiology Services and for specialty procedures such as a CT scan, MRI, or surgery. A written referral is also required for specialty-care visits to non-Medical Group physicians.

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

You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will find the specialty-care providers eligible to receive direct referrals in the Kaiser Permanente Physician and Provider Directory for your specific Service Area. It is available on our website, www.kp.org, by clicking on "Locate our services" then "Medical staff directory." You can get a paper copy of the directory by calling **Member Services**.

A self-referral provides coverage for routine visits only. 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 Plan Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Plan Physicians. ***Southern*** and ***Northern Colorado*** Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access," below). Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by Kaiser Permanente before Services are rendered.

The request for these Services can be generated by either your PCP or by a specialty-care provider. The physician or facility to whom you are referred will receive a notice of the authorization. You will receive a written notice of authorization in the mail. This notice will tell you the physician's name, address and phone number. It will also tell you the time period that the authorization is valid and the Services authorized.

3. Second Opinions

Upon request and subject to payment of any applicable Copayments 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 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 www.kp.org, click on "Locate our services" then "Facility directory."

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

When you select your PCP, you will receive your Services at that physician's office. You can find ***Southern*** and ***Northern Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Physician and Provider Directory for your specific 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 www.kp.org, click on "Locate our services" then "Facility directory."

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 and Non-Emergency, Non-Routine Care" in the "Benefits" section.

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office hours. Your office visit Charge, as defined in the "Summary Chart," will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after-hours Plan Facilities. The Charge for non-emergency, non-routine care received in Plan Facilities after regular office hours listed in the "Summary Chart," will apply. For additional information

about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.

Non-emergency, non-routine care received at a non-Plan Facility inside our Service Areas is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside our Service Areas, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized non-emergency, non-routine care outside our Service Areas. Please see "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section for coverage information about out-of-Plan non-emergency, non-routine care Services.

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 (not more than 90 days), 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 and Coinsurance described in this EOC. The 90-day limit on visiting member care does not apply to Members who attend an accredited college or vocational school.

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. Out-of-Area Student Benefit

A limited benefit is available to Dependents who are full-time students attending an accredited college, vocational or boarding school outside any Kaiser Foundation Health Plan service area. The out-of-area student benefit applies to covered Services, including prescription drugs that are covered under this EOC. We will pay 80% of Charges for covered Services. The Member is responsible for paying the remaining 20% of Charges. The benefit is limited to $1,200 per year.

To qualify for the out-of-area student benefit, the Dependent must: (1) be under the Group's Dependent age limit; and (2) carry at least 12 credit hours per term. Verification of student status will be necessary. For more information, please call **Member Services**.

Visiting member care will continue to apply to students attending an accredited college or vocational school in other Kaiser Foundation Health Plan or allied plan service areas.

Exclusions and Limitations:

1. Services received outside the United States are not covered.
2. Transplant Services are not covered.
3. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services, Non-Emergency, Non-Routine Care) are not covered under the Out-of-Area Student Benefit.
4. This benefit does not apply towards the Out-of-Pocket Maximum and is not subject to the Deductible.

G. 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 out-of-Plan non-emergency, non-routine care). 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.

H. 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.

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 has been victimized by fraud, please call **Member Services** to report your concern.

I. Cross Market Access

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

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

2. ***Southern*** and ***Northern Colorado*** Members:
   Southern and ***Northern Colorado*** Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder*** Service Area.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; after-hours 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 Service Area and at which designated Kaiser Permanente Plan Medical Offices, if applicable, you may receive Services at, please call **Member Services**.

IV. BENEFITS

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the Services are 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.
- The Services are provided, prescribed, authorized or directed by a Plan Physician. 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) "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care".
- 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) "Getting a Referral" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care").
- You have met any Deductible requirements described in the "Summary Chart."

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations and Reductions" 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 "Summary Chart."

A. Outpatient Care

Outpatient Care for Preventive Care, Diagnosis and Treatment

We cover, under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following outpatient care 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.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by a Plan Physician.
9. Medical social Services.
10. Preventive care Services (see "Preventive Care Services" in this "Benefits" Section for more details).

NOTE: To determine if your Group has the bariatric surgery benefit, see the "Summary Chart." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits" 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 a Plan Physician determines 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. **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 his/her own Copayments, Deductibles and Coinsurance requirements.
   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 "Summary Chart." 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.

C. 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.

D. 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 approved by Kaiser Permanente 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.

   Mental health Services required in connection with the treatment of chemical dependency are covered as provided in the "Mental Health Services" section below.

   Members who are disruptive or abusive may have their membership terminated for cause.

4. Chemical Dependency Services Exclusion: Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

E. 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 Medical Group; 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. Please see the "Summary Chart" for more information.

F. 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**.

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*** and ***Northern Colorado*** Service Areas, at pharmacies designated by Health Plan. You may obtain these drugs at the Copayment or Coinsurance shown on the "Summary Chart." 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 coverage includes supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance applies for these types of drugs. For more information, please refer to the prescription drug benefit description following your "Summary Chart."

      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 "Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." If your prescription drug Copayment or Coinsurance shown on the "Summary Chart" 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.

   c. Administered Drugs

      If the following are administered (1) during a covered stay in a Plan Hospital or Skilled Nursing Facility; or (2) in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable Copayment or Coinsurance shown on the "Summary Chart."

      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.

   d. 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. 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**.

   e. 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 "Summary Chart."

f. Food Supplements
Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. 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.

g. 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 "Summary Chart," 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. ***Denver/Boulder*** Service Area: Compound medications are covered as long as they are on the compounding formulary.
c. ***Southern*** and ***Northern Colorado*** Service Areas: Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.

3. 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 "Summary Chart."
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 "Summary Chart."
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. Unless approved by Health Plan, drugs:
i. Not approved by the FDA; and
ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. (***Denver/Boulder*** Members only)
m. Prescription drugs necessary for Services excluded under this Evidence of Coverage.

G. 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 (LCD) (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.

Limitation: 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.

   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. More than one piece of DME serving essentially the same function, except for replacements, spare equipment or alternate use equipment is not covered.

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 prostheses 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 in newborn Members 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 accord 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."

H. Early Childhood Intervention Services

1. Coverage
   Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for Early Intervention Services (EIS) up to the maximum amount permitted 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 as a non-Member for any EIS received after the maximum amount permitted by State law is satisfied.

2. Limitations
   The maximum amount of coverage permitted 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 Evidence of Coverage.

I. Emergency Services and Non-Emergency, Non-Routine 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," below, 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** and/or **Quality Resource Coordinator**.

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:
   i. Services outside our Service Area for conditions that, before leaving the Service Area, you knew or should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery performed by Plan Physicians, full-term delivery and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.
   ii. 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 or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

2. Non-Emergency, Non-Routine Care
   a. Non-Emergency, Non-Routine Care Provided by Plan Providers
      i. ***Denver/Boulder*** Service Area

      Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities **during** regular office hours. If you need non-emergency, non-routine care during office hours and you are a Member in the ***Denver/Boulder*** Service Area, you can visit one of our Plan Facilities.

      Non-emergency, non-routine care needed **after hours**, that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services**.

      During regular office hours, please call **Advice Nurse** 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.

      After office hours, please call **After-Hours Medical Needs** for a recorded message about your options and/or to speak with the answering service who will redirect your call, 24 hours a day, 7 days a week.

      ii. ***Southern*** and ***Northern Colorado*** Service Areas

      Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities during regular office hours. If you are a ***Southern*** or ***Northern Colorado*** Member and need non-emergency, non-routine care during regular office hours, please call your Plan Physician's office.

      Non-emergency, non-routine care needed **after hours**, that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, *www.kp.org*, for information on designated after-hours facilities.

      After office hours, please call your Plan Physician or go to the provider directory or to our website, *www.kp.org*, for information on our designated after-hours facilities. You may also call the nurse advice line at the telephone number listed in your provider directory or our website, *www.kp.org*.

   b. Out-of-Plan Non-Emergency, Non-Routine Care

      There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside our Service Area. Non-emergency, non-routine care received from non-Plan Providers is covered only when obtained outside our Service Area, 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.

3. Payment
   a. Health Plan's payment for covered out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services 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 accord 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.

   b. Our payment is reduced by:
      i. the Copayment and/or Coinsurance for Emergency Services and Special Procedures performed in the emergency room. The emergency room and Special Procedures Copayment, 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. any other payments you would have had to make if you received the same Services from our Plan Providers; and

v. 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
vi. amounts you or your legal representative recovers from motor vehicle insurance or because of third-party liability.

Note: The procedure for receiving reimbursement for out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is described in the "Internal Claims and Appeals Procedure and External Review" section, below.

J. Family Planning Services

We cover the following:

1. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control.
2. Tubal ligations.
3. Vasectomies.
4. Voluntary termination of pregnancy.

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

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

K. Health Education Services

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

L. Hearing Services

1. Persons Under the Age of 18 Years

   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 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. Persons Age 18 Years and Older

   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions:

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

M. Home Health Care

1. Coverage

   We cover skilled nursing care, home health aide Services and medical social Services:

   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only if you are confined to your home; 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. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by Health Plan on a case-by-case basis.

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

3. Special Services Program

If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). This Program allows you to receive up to 15 home health visits per lifetime. These visits are covered under the Special Services Program until you elect hospice care coverage. Coverage of hospice care is described below.

This Program gives 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 this Program and regular 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.

N. 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 accord with our drug formulary guidelines.
h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
i. Counseling and bereavement Services.
j. Services of volunteers.

O. 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 "Summary Chart."

P. 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.

a. Outpatient Therapy

We cover: diagnostic evaluation; individual therapy; psychiatric treatment; 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.

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 a Plan Physician determines such evaluation to be 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. Please refer to "Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services" for coverage of autism spectrum disorders.
c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.
d. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
e. Services which are custodial or residential in nature.

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

1. Coverage

a. Hospital Inpatient Care, Care in a Skilled Nursing Facility and Home Health Care

We cover physical, occupational and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period.

b. Outpatient Care

We cover three (3) types of outpatient therapy (i.e., physical, occupational and speech therapy) in a Plan Facility if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period. See the "Summary Chart."

c. Multidisciplinary Rehabilitation Services

If, in the judgment of a Plan Physician, significant improvement in function is achievable within a two-month period, we will cover treatment for up to two (2) months per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility.

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. Clinical criteria are used to determine appropriate candidacy for the program, which consists of: an initial evaluation; up to six (6) education sessions; up to twelve exercise sessions; and a final evaluation to be completed within a two to three-month period. See the "Summary Chart."

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 year for each physical, occupational and speech therapy. Such visits shall be distributed as Medically Necessary throughout the year 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 "Summary Chart."

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 children under the age of 19, we cover the following therapies for the treatment of Autism Spectrum Disorders:

i. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by a Plan Physician as Medically Necessary. See the "Summary Chart."
ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted by State law. See the "Summary Chart."

2. Limitations:

a. Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature.
b. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions:

a. Long-term rehabilitation, not including treatment for autism spectrum disorders.

b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

R. 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.

S. Reconstructive Surgery

1. Coverage

   We cover reconstructive surgery when a Plan Physician determines 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 (port wine stains) on the face and neck of Members 18 years and younger. 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.

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.

T. Skilled Nursing Facility Care

1. Coverage

   We cover up to 100 days per year of 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-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 "Drugs, Supplies and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray laboratory and special procedures, see "X-ray, Laboratory and Special Procedures".

2. Skilled Nursing Facility Care Exclusion: Custodial Care, as defined in "Exclusions" under "Exclusions, Limitations and Reductions", below.

U. 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 shown on the "Summary Chart."

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 accord 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 "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices.**

V. Vision Services

1. Coverage

   We cover wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. 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."

W. X-ray, Laboratory and Special Procedures

1. Coverage
   a. Outpatient

      We cover the following Services:
      i. Diagnostic X-ray and laboratory tests, Services and other materials, including isotopes, electrocardiograms, electroencephalograms and mammograms
      ii. Therapeutic X-ray Services and materials
      iii. Special procedures such as MRI, CT, PET and nuclear medicine. **Note:** Members 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. The Member is responsible for any applicable Copayment or Coinsurance for Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.

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 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.

V. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

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" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services:
   a. Acupuncture Services.
   b. naturopathy Services.
   c. massage therapy.
   d. chiropractic Services and Services of chiropractors.
   See the "Summary Chart."

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 major improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits" 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 for newborn Members 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 Hospital, Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if a Plan Physician determines they are 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" 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.

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 out-of-Plan non-emergency, non-routine care.

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. **Transgender Identity Disorder**. Services related to transgender identity disorder and sexual reassignment, including but not limited to, hormone therapy, surgery and psychosocial assessments for surgery.

18. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines 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 under "Getting a Referral" in the "How to Obtain Services" section. Travel and lodging expenses are not covered for Members who are referred to a non-Plan Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

19. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not een 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.

20. **Weight Management Facilities.** Services received in a weight management facility.

21. **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 of the National Association of Insurance Commissioners. Those guidelines are part of this EOC. For Members entitled to Medicare, Medicare is the primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and Medicare coverage be secondary. The COB guidelines determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

   If your coverage under this EOC is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during the year to pay for your out-of-pocket expenses for Services that are partially covered by either us or your other coverage. If you are entitled to a Benefit Reserve Account, we will give you information about this account.

   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 reimburse us 100% of Charges 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.

   If you are involved in an automobile-related accident, please contact **Patient Financial Services** right away so that we can coordinate benefits with the automobile insurance carrier and determine whether we or the automobile insurance carrier has primary coverage. 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, but we will be subrogated only to the extent of the total Charges for the relevant Services.

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. The proceeds of any judgment or settlement that you, your attorney or your representative get shall first be applied to fully satisfy our lien, even if the total amount of your recovery from all sources is less than the actual or estimated losses and damages you incurred, and without regard of how the proceeds are characterized or itemized. We deny any application of the Made Whole doctrine.

We will not be responsible for any fees you incur to obtain any judgment or settlement. Costs we incur will be borne by us. Costs of your representation will be borne by you. We deny any application of the Common Fund doctrine. 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 any other party, you must send written notice of the claim or legal action to: **Patient Financial Services**. 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, 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.

Note: For recoveries on or after August 11, 2010, reimbursement for benefits will be governed by state law.

3. Surrogacy
   In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement of Charges for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, up to the monetary amount you receive to act as a surrogate. 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.

VI. INTERNAL CLAIMS AND APPEALS PROCEDURE AND EXTERNAL REVIEW

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 "Internal Claims and Appeals Procedures and External Review" 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,
   b. terminate your membership retroactively except as the result of non-payment of premiums (also known as rescission), 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.

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

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described below in this "Internal Claims and Appeal Procedures and External Review" section.

Language and Translation Assistance

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then your notice of adverse benefit determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally

mandated non-English language. You may request language assistance with your claim and/or appeal by calling **Member Services**. We offer language assistance by calling **Member Services**.

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

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then you may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling **Member Services**.

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
(3030) 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
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

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; (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 claim be treated as urgent.

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. 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 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 wend you written confirmation within 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. In addition, you may also tell us 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 must either mail or fax your appeal 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 "Claims and Appeals Procedures" 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 you 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 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 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 the **Appeals Program**.

Unless you are appealing an urgent care claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you 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 you will have to pay for the Services that we decide are not covered.

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 the **Appeals Program**.

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 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. 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 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 appeal to the **Appeals Program**.

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

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

c. Urgent Concurrent Care Appeal
Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal 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 "Claims and Appeals Procedures" 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 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 3 days after that.

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

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

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

a. Post-Service Claim
Within 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. 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. Your 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.

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 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.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least 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 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 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 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 First Level Appeal or Voluntary Second Level Appeal decision letter, 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 medical judgment including one based on our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a

covered service, network provider expertise or access, or our determination that the requested care or service is experimental or investigational. If our final adverse decision does not involve medical judgment, 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.

To request external review, you must 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 another copy of this form) to the **Appeals Program** within 4 months of the date of receipt of the mandatory internal appeal decision or within 60 days of receipt of our Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be 3 days after the date on which our notice was drafted, unless you can prove that you received our notice after the 3 day period ends.

If we do not receive your external review request form, 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.

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 external review criteria when you submit your request for external review along with the other required information (described, above). No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

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 appealing the denial to the Division of Insurance. At the same time that we send this 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 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 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 within 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 that the external review decision is the final appeal available under state insurance law.

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 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.

VII. MEMBER SATISFACTION PROCEDURE

A. 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 following the procedures listed below.

1. Sending your written complaint to **Member Services**; or
2. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
3. Telephoning **Member Services**.

B. After you notify us of a complaint, this is what happens:

1. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
2. The Member Services Liaison or a Plan Physician evaluates the facts and makes a recommendation for corrective action, if any.
3. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
4. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

C. 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**.

VIII. TERMINATION OF MEMBERSHIP

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 meet the eligibility requirements in Section II on the first day of a month, then become ineligible, your membership terminates on the last day of that month unless your Group has agreed to a different termination date. Please check with your Group's benefits administrator to confirm your termination date.

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 by sending written notice to the Subscriber at least 15 days before the termination date if anyone in your Family Unit commits any of the following acts:

1. 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
2. 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
3. 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
4. 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 not be allowed to convert to non-group coverage or to re-enroll in Health Plan. 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

1. Nonpayment of Dues

   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.

2. Nonpayment of Any Other Charges

   We may terminate your membership if you fail to pay any amount you owe Health Plan or to a Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. If we receive full payment before the termination date, we will not terminate your membership. Also, if we terminate your membership for nonpayment of any other Charges, we will reinstate your membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date.

   Persons whose memberships are terminated for nonpayment of any other Charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment.

E. 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 and Enrollment" 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.

   NOTE: If your Dependent child ceases to qualify as an eligible Dependent under Health Plan, such as reaching the age constraints, he/she may elect to convert to a non-group plan on a direct pay basis (see "Eligibility and Enrollment" and "Conversion of Membership" for more details).

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.

F. Conversion of Membership

You may be eligible to convert to a non-group plan on a direct pay basis if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section or if you enroll in COBRA or USERRA continuation coverage and then lose eligibility for that COBRA or USERRA coverage. However, you may not convert to this non-group plan if:

1. you continue to be eligible for coverage through your Group; or
2. you live in another Kaiser Foundation Health Plan or allied plan service area, except that the Subscriber's or the Subscriber's spouse's otherwise eligible children are not ineligible to be covered Dependents solely because they live in another Kaiser Foundation Health Plan or allied plan service area if: (a) they are attending an accredited college or accredited vocational school, or (b) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO); or
3. your membership ends because our Agreement with your Group terminates; or
4. we terminated your membership under "Termination for Cause" or "Nonpayment of Any Other Charges" in this "Termination of Membership" section.

You must apply to convert your membership within 31 days after your Group coverage ends. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Dues, and the benefits and Copayments or Coinsurance under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, please call **Member Services**.

G. 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. 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:

A. Performed an act, practice, or omission that constitutes fraud; or
B. 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.

X. MISCELLANEOUS PROVISIONS

A. Administration of Agreement

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

B. 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**.

C. 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.

D. 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.

E. 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.

F. Assignment

You may not assign this EOC or any of the rights, interests, or obligations hereunder without our prior written consent.

G. 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.

H. 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.

I. Contracts with Plan Providers

Your 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.

J. Deductible Takeover Credit

Deductible takeover 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. 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 under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible 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 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 **Claims Customer Service**.

K. Governing Law

Except as preempted by federal law, this EOC will be governed in accord 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.

L. Group and Members not Health Plan's Agents

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

M. 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.

N. 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.

O. 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.

P. 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.

Q. 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, *www.kp.org*.

XI. DEFINITIONS

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

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

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).

The schedules, amounts, and payments on which Charges are based may change at any time without notice.

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 "Summary Chart."

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Summary Chart."

Deductible: The amount you must pay in a year for certain Services before we will cover those Services in that year. The "Summary Chart" 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 and Enrollment" 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.

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.

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 Coinsurance you must pay in a year for covered Services, as described in the "Summary Chart."

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. 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 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, 80028, 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, 80154, 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, 80254, 80255, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80270, 80271, 80273, 80274, 80275, 80279, 80280, 80281, 80285, 80290, 80291, 80292, 80293, 80294, 80295, 80299, 80301, 80302, 80303, 80304,

80305, 80306, 80307, 80308, 80309, 80310, 80314, 80321, 80322, 80323, 80328, 80329, 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, 80513, 80514, 80516, 80520, 80530, 80533, 80534, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80601, 80602, 80603, 80614, 80621, 80623, 80640, 80642, 80643, 80651.

The ***Northern Colorado*** Service Area is that portion of Adams, Albany, Larimer, Morgan, and Weld counties within the following zip codes: 80511, 80512, 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, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82070.

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, 80940, 80941, 80942, 80943, 80944, 80945, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81013, 81014, 81015, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81246, 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 legal husband or wife.

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).

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 and Enrollment" section).

XII. APPENDIX

A. Access Plan

Colorado State 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 foreign 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. Binding Arbitration

Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)"), which arise from any alleged failure or violation of, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

You must use Health Plan procedures to request arbitration. You can get a copy of these procedures from our **Resolve Programs** department. The arbitration hearing will be held in accord with Health Plan procedures, the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

D. 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, *www.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.

E. Women's Health and Cancer Rights Act

In accord 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.

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2013 Large Group – Kaiser Group Agreement for the City and County of Denver

Exhibit D – Evidence of Coverage Amendments

CITY AND COUNTY OF DENVER

EVIDENCE OF COVERAGE AMENDMENT - 2013

I. The following eligibility and enrollment requirements are *in addition* to those detailed in this Evidence of Coverage (EOC), Eligibility and Enrollment section.

ELIGIBILITY AND ENROLLMENT

Eligible Dependents

The following persons qualify as **Dependents**:

- Any spouse, including those defined as common-law in the state and Same Gender Domestic Partners (a.k.a. Spousal Equivalent).
- Any child meeting the Dependent Age Limits. This includes:
  - A step-child;
  - A child for whom the Insured Employee or his/her spouse is required by a qualified medical child support order to provide health care coverage;
  - A child for whom you or your spouse has court-ordered custody;
  - An adopted child;
  - A child placed for adoption; or
  - An unmarried incapacitated and physically disabled child who is a legal dependents of the Insured Employee or his/her spouse, who meets the eligibility requirements set forth in the Summary Plan Description and Disclosure Form and for whom applicable Dues are received.

The following persons qualify as **Same Gender Domestic Partners (a.k.a. Spousal Equivalent)**:

- An adult of the same gender who shares an emotional, physical, and financial relationship with the employee, similar to that of a spouse, who:
  - Is 18 years of age or older;
  - Is mentally competent to consent to contract;
  - Has an exclusive, committed relationship with the subscriber with the intent for the relationship to last indefinitely;
  - Shares basic living expenses with the Subscriber;
  - Is unmarried; and
  - Is not related by blood to the Subscriber such as a parent, brother, sister, half brother, half sister, niece, nephew, aunt, uncle, grandparent or grandchild.
- A subscriber of the group may enroll a sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) of the same sex and children of the sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) as Eligible Dependents.

Dependent Child Age Limits:

- A dependent shall be covered to the end of the month that he/she turns age 26.
- Unmarried legal dependents who are mentally or physically disabled shall be covered regardless of age.

II. The following requirements regarding Domestic Partnership coverage supersede those detailed in the Domestic Partner rider found at the end of this Evidence of Coverage (EOC) booklet:

The Subscriber and the sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) must complete an **Affidavit of Domestic Partnership** confirming the following information:

- The partners have an exclusive, committed relationship and hold ourselves out as committed partners.
- Both partners share basic living expenses with the intent for the relationship to last indefinitely.
- Are both 18 years of age or older;

- Neither partner is married;
- Neither partner is related by blood to the other as described above; and
- Neither partner has had a different domestic partner within six (6) months of filing with the employer a statement of termination of domestic partnership.

The Affidavit of Domestic Partnership is available through the Group's Benefit Manager and will be maintained by the employer. The Employee must immediately notify the employer in writing if the circumstances attested to in the Affidavit change.

III. The following information is added and becomes part of this Evidence of Coverage (EOC):

Eligible Employee Definition. An Eligible Employee is;

- A Subscribing City and County of Denver employee who works a fixed number of hours established by the City and County of Denver, and meets any other eligibility requirements as set forth in Code Section 18-171 of the Denver Revised Municipal Code ("Denver Code");
- An eligible employee of the Denver Employees' Retirement Plan (DERP);
- An eligible retired member of DERP who is not eligible for Medicare, and who satisfies any applicable waiting period of the City and County of Denver; or
- A member who is not retired, but is defined as an employee under State and Federal Law.
- A person listed under "with the exception of:" as set forth in Denver Code Section 18-171 (1)(a) through (d) is *not* an Eligible Employee.

Additional Requirements for Subscribing Employees of the City and County of Denver: The following conditions of enrollment and eligibility shall be applicable to Subscribing Employees of the City and County of Denver, in addition to the conditions specified above and in the attached Evidence of Coverage brochure. If any of the following conditions contradict those stated in the attached Evidence of Coverage brochure, the conditions stated here shall prevail.

- **Eligibility Rules**: Required regular work each week is 20 hours per week or greater, except no work week requirement for eligible retirees.
- **New hire waiting period**: Employees and dependents are eligible on the first day of the month which follows the employee's initial date of employment.
- **New Employee Coverage Effective Date**: The first day of the month which follows the employee's initial date of employment.
- **Standard Leave of Absence**.
    - A Member who elects to take an authorized Standard Leave of Absence may be eligible for coverage as permitted by Career Service Rules, established by the Career Service Board in accordance with its rule-making power granted under Denver Charter Section 9.1.1 and Denver Code Section 18-2.
    - The Family Medical Leave Act of 1993 (FMLA) allows a worker up to 12 weeks of leave under certain circumstances.

2013 Large Group – Kaiser Group Agreement for the City and County of Denver

Exhibit E – 2013 Performance Guarantees Agreement

KAISER PERMANENTE®

Kaiser Permanente Colorado
2013 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 2013. (In 2014 we will conduct a review of your 2013 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 2013 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.

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Kaiser Permanente Colorado
2013 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%)

	2013 Performance Measures	Penalty Threshold	Penalty (% of Premium)
Implementation, Administration and Account Management			
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 within10 business days	93%	0.11%
4.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.12%
Member Services			
5.	Member Services calls answered within 30 seconds	80%	0.10%
6.	Telephone call abandonment rate	≤ 3.0%	0.10%
Member Satisfaction and Access			
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%
Quality (HEDIS Effectiveness of Care)			
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.	Antidepressant Medication Management (Acute Phase)	≥ 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

2013 Large Group – Kaiser Group Agreement for the City and County of Denver

Exhibit F – Underwriting Assumptions and Requirements

Rate Assumptions and Requirements

Group Name: CITY AND COUNTY OF DENVER

Group Numbers: 75

Subgroups: 001,002,003,007,008,009,010, 011,020,022

Region: Colorado

Contract Period: 01/01/2013 - 12/31/2013

KP Offered: Alongside other carrier(s)

Quotes Included

DB SC NC - DHMO - 8538866

DB SC NC-HMO - 8538869

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 1/1/2013 through 12/31/2013 unless otherwise specified above.
   The rates and benefits in this proposal include the Federal Health Care Reform requirements for dependent coverage to age 26 and the elimination of lifetime maximums, including durable medical equipment (DME) annual maximums for contracts with renewal dates of October 1, 2010 or later. 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 rerate 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.
   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.
   c. The employer's contribution formula does not put KP in a disadvantaged position. Acceptable formulas include, but are not limited to, fixed employer dollar or percentage contribution.
   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. The number of employee subscribers enrolled in KP must 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.

5. **Product-specific participation requirements:**

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. 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. Members with only Part B may also enroll but their rates will be subject to a surcharge.
b. 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.
c. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
d. 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 employer must have an employer/employee relationship to those offered a KP Plan.
   - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and working a minimum of 20 hours per week. 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.
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.

Rate Assumptions and Requirements

Group Name: CITY AND COUNTY OF DENVER

Group Numbers: 75

Subgroups: 001,002,003,007,008,009,010, 011,020,022

Region: Colorado

Contract Period: 01/01/2013 - 12/31/2013

KP Offered: Alongside other carrier(s)

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