TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

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

This EOC is for your Group's 2019 contract year.

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KAISER PERMANENTE®

NONDISCRIMINATION NOTICE

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

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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

HELP IN YOUR LANGUAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

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

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

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

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

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

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

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
7. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
8. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
10. The family Deductible and OPM amounts are applicable for a newborn child, even if the newborn is covered only for the first 31 days that is required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

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

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

   1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
   2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
   3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

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

II. ANNUAL OUT-OF-POCKET MAXIMUMS

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

For covered Services that apply to the OPM, any amounts over usual, reasonable and customary charges will not apply toward the OPM.

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

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

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

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

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

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

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

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a July 1 to June 30 Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$3,500/Individual per Accumulation Period $7,000/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Allergy evaluation and testing *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit Copayment may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance with $100 maximum
• Travel immunizations	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a doctor online via kp.org	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$350 Copayment each surgery
Outpatient hospital Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $350

Hospital Inpatient Care	You Pay
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$600 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

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

Ambulance Services	You Pay
(Applies to Out-of-Pocket Maximum)	$50 Copayment per trip

Bariatric Surgery	You Pay
(Applies to Out-of-Pocket Maximum)	30% Coinsurance Includes inpatient and outpatient covered Services

Chemical Dependency Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$600 Copayment per admission
Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit $30 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$600 Copayment per inpatient admission

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

Dialysis Care	You Pay
(Applies to Out-of-Pocket Maximum)	$50 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	No Charge See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	No Charge
• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	No Charge
Orthotic devices *(Applies to Out-of-Pocket Maximum)*	No Charge
Oxygen *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and non-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.

Urgent Care	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.
Urgent care outside Service Area *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.
Covered only if all the following requirements are met: • The care is required to prevent serious decline of health • The need for care results from an unforeseen illness or injury when temporarily away from our Service Area • The care cannot be delayed until you return to our Service Area	

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

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

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
• Fitting and recheck Visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck Visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Physician *(Applies to Out-of-Pocket Maximum)*	No Charge

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

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$600 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit $30 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections. Office vists do not include: allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, hearing aids, hearing tests, home health visits, hospice services, and applied behavioral analysis (ABA))* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services: (Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment Limited to 5 therapy visits (any combination) per Accumulation Period
Outpatient prescription drugs *(Not subject to pharmacy Deductible)*	Limited to 5 prescription drug fills per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs	
o Contraceptive drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
o Over the counter (OTC) items: *(Includes federally mandated over the counter items)*	No Charge
o Tobacco cessation drugs	No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	
• Habilitative Services	$30 Copayment each visit Up to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$30 Copayment each visit Up to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit

Prescription Drugs, Supplies, and Supplements	You Pay
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand name Contraceptive drugs at No Charge
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Over the counter (OTC) items: *(Includes federally mandated over the counter (OTC) items . OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
• Preventive tier drugs	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $100 per drug dispensed Insulin @ applicable Copayment/Coinsurance
• Tobacco cessation drugs	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge
Colorectal cancer screenings *(Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a doctor online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance

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

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

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Up to 100 days per Accumulation Period

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

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See “Office Services” for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Test: $30 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $50 Copayment each visit Test: $50 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $50 Copayment each visit Test: $50 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See “Office Services” for “Office-administered Drugs”.)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

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

IV. DEPENDENT LIMITING AGE

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

Additional Provisions

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

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week	
CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**: 970-207-7171** or toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health	
CALL	***Denver/Boulder*** Members: **303-471-7700** ***Southern Colorado*** Members: **1-866-702-9026** ***Northern Colorado*** Members: **303-471-7700** ***Mountain Colorado*** Members: **1-866-702-9026**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services	
CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-844-201-5824** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

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

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

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

Patient Financial Services	
CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-844-201-5824** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Personal Physician Selection Services	
CALL	***Denver/Boulder*** Members: **303-338-4477** ***Southern Colorado*** Members: **1-855-208-7221** ***Northern Colorado*** Members**: 1-855-208-7221** ***Mountain Colorado*** Members: **1-855-208-7221**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**kp.org/locations** for a list of providers and facilities

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

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I. ELIGIBILITY

A. Who Is Eligible

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

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. 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 regional health plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services**.

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

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

   a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)
   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."
   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.
   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

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

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

B. Enrollment and Effective Date of Coverage

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

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

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

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

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

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
For existing Subscribers:
   i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
   ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
For existing Subscribers:
   i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
   ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

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

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

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

6. Persons Barred from Enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

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

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

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Cross Market Access" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.

- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

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

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

A. Your Primary Care Provider

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

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine within your home Service Area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section.

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

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

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

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

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

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

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

2. Changing Your Primary Care Provider

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

   Please call **Personal Physician Selection Services** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

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

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

B. Access to Other Providers

1. Referrals and Authorizations

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

   If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

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

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

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

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

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

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

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

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

2. Specialty Self-Referrals

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

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

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

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

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

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

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

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

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

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

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

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

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

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

   If the recommendations of the first and second physician differ regarding the need for surgery (or other major procedure), a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

C. Plan Facilities

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

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

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

2. ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that provider's office. You can find ***Southern, Northern,*** and ***Mountain Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from our website. Go to kp.org/locations.

D. Getting the Care You Need

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

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

Urgent care received at a non-Plan Facility inside your Service Area is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside your Service Area, you will be responsible for payment for any treatment received.

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

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, and/or Coinsurance, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

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

F. Moving Outside of Any Kaiser Regional Health Plan Service Area

If you move to an area not within any Kaiser regional health 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 regional health plan service area in order to receive covered Services (except out-of-Plan Emergency Services and urgent care outside the Service Area). If you go to another Kaiser regional health plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Regional Health Plan Service Areas" above.

G. Using Your Health Plan Identification Card

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

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

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

H. Cross Market Access

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

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

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

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

III. BENEFITS/COVERAGE (WHAT IS COVERED)

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

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

- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

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

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

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

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

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

    Note: If the following are administered in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to your Office Services Copayment or Coinsurance.

    Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and allergy test and treatment materials.

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

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

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

1. Outpatient surgery at designated Plan Facilities, including an ambulatory surgical center, surgical suite, or outpatient hospital facility.
2. Outpatient hospital Services at designated facilities, including but not limited to: sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

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

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

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

a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.

b. Intensive care and related hospital Services.

c. Professional Services of physicians and other health care professionals during a hospital stay.

d. General nursing care.

e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for child birth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn after your discharge are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.

f. Meals and special diets.

g. Other hospital Services and supplies, such as:
   i. Operating, recovery, maternity and other treatment rooms.
   ii. Prescribed drugs and medicines.
   iii. Diagnostic laboratory tests and X-rays.
   iv. Blood, blood products and their administration.
   v. Dressings, splints, casts and sterile tray Services.
   vi. Anesthetics, including nurse anesthetist Services.
   vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

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

D. Ambulance Services

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

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

E. Chemical Dependency Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

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

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

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

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

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

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

F. Clinical Trials

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

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

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

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

G. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Health Plan; and
4. A Plan Physician provides a written referral for care at the facility.

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

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

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

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

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

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

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

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

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

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

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

I. Early Childhood Intervention Services

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

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

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

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

J. Emergency Services and Urgent Care

1. Emergency Services
   Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

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

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

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

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

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

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

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

         We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible.

   b. Emergency Services Exclusions
      Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

   c. Payment

Our payment is reduced by:

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

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

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

2. Urgent Care

a. Urgent Care Provided by Plan Providers

i. ***Denver/Boulder*** Service Area

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

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

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

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

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

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

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

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside your Service Area. Urgent care received from non-Plan Providers outside your Service Area is covered only if all of the following requirements are met:

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

c. Payment for Urgent Care Outside the Service Area

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

i. does not exceed most Charges which providers in the same area charge for that Service; and
ii. does not exceed the usual Charge made by the provider for that Service; and

iii. is in accordance with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

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

Note: The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

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

K. Family Planning and Sterilization Services

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

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

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

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

L. Health Education Services

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

M. Hearing Services

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

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

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

N. Home Health Care

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

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

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

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

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

O. Hospice Special Services and Hospice Care

1. Hospice Special Services

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

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

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

2. Hospice Care

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

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

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

P. Mental Health Services

1. Coverage

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

   a. Outpatient Therapy

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

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

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

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

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

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

Q. Out-of-Area Benefit

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

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Chemical dependency visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

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

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

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

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
   We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care

requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)".

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

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We also cover multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

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

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

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

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

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

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

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

S. Prescription Drugs, Supplies, and Supplements

We use drug formularies. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees for our Members. Our committees are comprised of Plan Physicians, pharmacists and a nurse practitioner. The committees select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, please call **Member Services**.

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

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer

medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

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

Note: 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.

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

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

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

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

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We are not licensed to mail medications out of state. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs have a significant potential for waste and diversion. Those drugs are not available by mail-order service. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

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

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

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

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

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request an exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.
3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions".
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Individual drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

T. 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.

U. Reconstructive Surgery

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

V. Reproductive Support Services

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

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

W. Skilled Nursing Facility Care

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

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

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

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

X. Transgender Services

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

Y. Transplant Services

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

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

   c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

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

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

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

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

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

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

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

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   e. Orthoptic (eye training) therapy.

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

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

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, which includes but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds.
      ii. Laboratory tests, Services, and materials.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.
      iii. Therapeutic X-ray Services and materials.
      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery. Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.
   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered without Charge.

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

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

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

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

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

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

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

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

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

6. **Directed Blood Donations.**

7. **Disposable Supplies.** Disposable supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

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

9. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or

iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

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

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

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

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

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

11. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.

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

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

14. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.

15. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

16. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

17. **Special Education**. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or retardation, including but not limited to attention deficit disorder.

18. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
a. Employment;
b. Participation in employee programs;
c. Insurance;

d. Disability;
e. Licensing;
f. School events, sports, or camp;
g. Governmental agencies;
h. Court order, parole, or probation;
i. Travel.

19. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when Medical Group refers you to a non-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.

20. **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.

21. **Weight Management Facilities.** Services received in a weight management facility.

22. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

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

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

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

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

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

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

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.
ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

ORDER-OF-BENEFIT DETERMINATION RULES

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

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

b.
   i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.
   ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

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

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

   ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:
      A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
         2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

      B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
         2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
         3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
         4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
            - The **Plan** covering the **Custodial parent**;
            - The **Plan** covering the spouse of the **Custodial parent**;
            - The **Plan** covering **the non-custodial parent**; and then
            - The **Plan** covering the spouse of the **non-custodial parent**.

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

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

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

order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties

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

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

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

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

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

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

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

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

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

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

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

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

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

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

You must send this information to:

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

V. MEMBER PAYMENT RESPONSIBILITY

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

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan

Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

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

VII. GENERAL POLICY PROVISIONS

A. Access Plan

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

B. Access to Services for Foreign Language Speakers

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

C. Administration of Agreement

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

D. Advance Directives

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

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

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

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

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

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

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

G. Applications and Statements

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

H. Assignment

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

I. Attorney Fees and Expenses

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

J. Claims Review Authority

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

K. Contracts with Plan Providers

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

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

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

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

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

N. No Waiver

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

O. Nondiscrimination

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

P. Notices

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

Q. Out-of-Pocket Maximum Takeover Credit

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

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

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

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

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

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

Permanente Claims Department. To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

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

S. Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. 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 kp.org.

T. Value-Added Services

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

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

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

1. Show your Health Plan ID card; and
2. Pay the fee, if any, to the company that provides the value-added service.

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our:

1. Quarterly member magazine; or
2. Website, kp.org.

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

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

U. Women's Health and Cancer Rights Act

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

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

VIII. TERMINATION/NONRENEWAL/CONTINUATION

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

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

A. Termination Due to Loss of Eligibility

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

B. Termination of Group Agreement

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

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

C. Termination for Cause

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

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Physician has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

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

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

D. Termination for Nonpayment

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

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

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

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

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

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

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

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

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

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

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

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

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

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

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

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

H. Moving to Another Kaiser Regional Health Plan Service Area

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

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

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

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

2. An **adverse benefit determination** is our decision to do any of the following:

a. deny your claim, in whole or in part, including (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
c. uphold our previous adverse benefit determination when you appeal.

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

In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, then such evidence establishes that the denial is subject to the appeals process.

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

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section.

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

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

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

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

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

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

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

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

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

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

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

Internal Claims and Appeals Procedures

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

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

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

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

1. Pre-Service Claims and Appeals

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

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

   a. Pre-Service Claim

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

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

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

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

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

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

   b. Non-Urgent Pre-Service Appeal

      Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of

the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

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

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

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

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

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

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

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

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

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

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

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

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot

be adequately managed without extending your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15-day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request.

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

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

b. Non-Urgent Concurrent Care Appeal

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

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

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

c. Urgent Concurrent Care Appeal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voluntary Second Level Appeal
A Voluntary Second Level Appeal is another review by us that occurs after the mandatory internal appeal decision is communicated to you if you remain dissatisfied with our decision. This in-person review permits you to present evidence to the Second Level Appeal Panel and to ask questions. Choosing a Voluntary Second Level Appeal will not affect your right, if you have one, to request an independent external review.

Here is the procedure for a Voluntary Second Level of Appeal:

Within 30 days from the date of your receipt of our notice regarding your internal appeal, please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination (mandatory internal appeal decision), and (5) all supporting documents. Your request and the supporting documents constitute your request for a Voluntary Second Level of Appeal. You must mail your request to the **Appeals Program**.

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

You may present your appeal in person before the Second Level Appeal Panel, or request a file review. If you would like to present your appeal in person, but an in-person meeting is not practical, you may present your appeal by telephone. Please indicate in your appeal request how you want to present your appeal. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the Second Level Appeal meeting.

You may submit additional information with your appeal request, or afterwards but no later than five (5) days prior to the date of your Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to us as soon as practicable. You may present your case to the Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of your choice including an attorney (at your own expense), other advocate or health care professional. If you decide to have an attorney present at the Second Level Appeal meeting, then you must let us know that at least seven (7) days prior to that meeting. You must appoint this attorney as your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If you would like further information about the Voluntary Second Level Appeal process, to assist you in making an informed decision about pursuing a Voluntary Second Level Appeal, please call the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

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

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

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

To request external review, you must:

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

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

Expedited External Review

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

Additional Requirements for External Review regarding Experimental or Investigational Services

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

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

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

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

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

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

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

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

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

Additional Review

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

B. Complaints

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

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

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

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

X. INFORMATION ON POLICY AND RATE CHANGES

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

XI. DEFINITIONS

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

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

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

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

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

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

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

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

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

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: All of the following with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under the *Emergency Medical Treatment and Active Labor Act*) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the *Emergency Medical Treatment and Active Labor Act* requires to Stabilize the patient.

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

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

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

Kaiser Permanente: Health Plan and Medical Group.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:

- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan or non-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Dues. This EOC sometimes refers to a Member as "you" or "your."

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A Plan Medical Office or Plan Hospital.

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

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

Plan Optometrist: Any licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

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

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

Service Area:
The ***Denver/Boulder*** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80252, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80640, 80642, 80643.

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

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

The ***Southern Colorado*** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for both same- and opposite-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same- and opposite-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMPA0AA (01-18)

SPECIAL DEPENDENTS
(AKA Foster Children)

Special Dependents are a Dependent class not recognized by Health Plan unless agreed upon between the Group and Health Plan. Your Group has agreed to purchase Special Dependent coverage through this amendment as follows:

Health Plan and your Group agree to amend the "Who Is Eligible" section of the Evidence of Coverage (EOC) by adding foster children as eligible Dependents. A foster child must meet the Dependent eligibility requirements described in that section.

SPEC0AD (01-15)

ELIGIBILITY AND ENROLLMENT

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

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

WOR0AA (01-10)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to contracted providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.

n. MRI and/or other types of diagnostic radiology.
o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for Chiropractic Care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-18)

ACUPUNCTURE SERVICES

1. Coverage
   Acupuncture Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted acupuncturists and if clinically appropriate.

   Coverage includes treatment for:
   a. Neuromusculoskeletal pain due to an injury or illness; or
   b. Allergy, asthma, nausea or vomiting.

   Services include:
   a. Acupuncture by manual stimulation.
   b. Electro-acupuncture applied to inserted needles and acupressure.

   Cupping or moxibustion are only covered in lieu of electrical stimulation.

   You may self-refer for visits to contracted acupuncturists.

2. Acupuncture Services Exclusions:
   a. Rental or purchase of durable medical equipment (DME);
   b. Air purifiers, therapeutic mattresses, supplies or similar devices, appliances, or equipment. Their use or installation does not have to be for therapy or easy access;
   c. Radiology and lab tests;
   d. Prescription drugs, vitamins, herbs or food supplements. It does not matter if they are prescribed or recommended by a contracted acupuncturist;
   e. Massage or soft tissue techniques, except acupressure;
   f. Treatment mainly for obesity or weight control;
   g. Vocational, stroke or long term rehabilitation;
   h. Hypnotherapy;
   i. Behavior training;
   j. Sleep therapy or biofeedback;
   k. Acupuncture Services provided for maintenance or preventive care Services;
   l. Addiction. This includes quitting smoking;
   m. Expenses for acupuncture Services provided during visits that exceed the member's visit limit;
   n. Expenses for any Services provided before coverage begins or after coverage ends for this benefit;
   o. Any Services provided by an acupuncturist who is not contracted. It does not matter if the Services are obtained in or out of Health Plan's Service Area;
   p. Acupuncture Services that Health Plan determines are not clinically appropriate in its utilization review. (Members may not be surcharged for such Services);
   q. Services not authorized by Health Plan. This exclusion does not apply to the initial evaluation;
   r. Any techniques or procedures not generally accepted in a majority of state acupuncture licensing boards; and
   s. Benefits, items, or Services that are limited or excluded in the EOC, unless changed by this benefit.

This rider amends the EOC to provide limited coverage for acupuncture Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CMPL0AA (01-19)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge.

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

Limitations: Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage:
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.
   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.
   c. Durable Medical Equipment Exclusions:
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost equipment.
      viii. Repairs, adjustments or replacements necessitated by misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements.
      x. Spare equipment or alternate use equipment is not covered.
2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.
   b. Prosthetic Devices Exclusions:
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost prosthetic devices.
      vi. Repairs, adjustments or replacements necessitated by misuse.
3. Orthotic Devices
   a. Coverage
      Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.
   b. Orthotic Devices Exclusions:
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accord with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.

ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract.
iii. Experimental and research braces.
iv. More than one orthotic device for the same part of the body, except for covered replacements.
v. Spare devices or alternate use devices.
vi. Replacement of lost orthotic devices.
vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":
   a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations
   a. IUI coverage is limited to three (3) treatment cycles per lifetime.
   b. Services are covered only for the person who is the Member.

3. Exclusions
   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen and/or eggs, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
   f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for Reproductive Support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-19)

PREVENTIVE SERVICES RIDER

Preventive care services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Physician. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Copayment or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Copayment or Coinsurance for these additional non-preventive Services.

- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Copayment or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening of adults and tobacco cessation interventions by your primary care provider.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD (01-18)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at kp.org/formulary.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. If you are an active Member and the exception request is granted, Health Plan will provide coverage of the non-formulary drug for the duration of the prescription. If the exception request is denied, you, your designee, or your Plan Provider may request an external review of the decision by an independent review organization. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

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

For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and that are not listed as generic in the then-current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

Prescription drugs are covered only when prescribed by a:

a. Plan Physician and obtained at Plan Pharmacies; or
b. Physician to whom a Member has been referred by a Plan Physician and obtained at Plan Pharmacies; or
c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

Covered drugs include:

a. Drugs for which a prescription is required by law. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, you pay only the brand-name Copayment or Coinsurance.

b. Insulin.

c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.

d. Compounded medications. **Note:** In all Service Areas, if you use a Kaiser Permanente pharmacy, compounded medications must be picked up or mailed from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on *kp.org*, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance. In the ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas, you may fill or refill compounded medications at a network pharmacy.

2. Limitations
   a. Some drugs may require prior authorization.
   b. We may apply Step Therapy to certain drugs. You or your Plan Provider may request an exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Individual drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for Prescription Drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

TABS0AD

ABORTION EXCLUSION

Coverage:

Medical services necessary to prevent the death of either a pregnant woman or her unborn child under circumstances where every reasonable effort is made to preserve the life of each.

Exclusions:

1. Voluntary, elective abortions and any related Services.
2. Therapeutic abortions performed when the pregnancy is the result of an act of rape or incest.

TABS0AD (01-16)

NOTES

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

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SBCCOE EMPLOYEE BENEFITS TRUST

Important plan information

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