Important Benefit Information Enclosed

Evidence of Coverage

State of Colorado
Kaiser HDHP with HSA
Denver Boulder/Northern Colorado/Southern Colorado
FY 2015
Plan Year effective July 1, 2014 – June 30, 2015

kp.org

KAISER PERMANENTE®

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IMPORTANT NOTICE

The definition of Eligible Dependent has been modified to include the definition of Spouse as recognized under federal tax law.

Eligible Dependent: Eligible dependents are specified in statutes, primarily § 24-50-603(5) and (6.5), C.R.S., as modified or further defined by other state statutes (e.g., Title 10) or federal regulations (e.g., Affordable Care Act [ACA], IRC on taxable income).

A. Current Spouse, including Common Law Spouse
   1. A Spouse as recognized under federal tax law.
   2. Common Law Spouse means an adult,
      a. Who is at least 18 years of age; and
      b. With whom the Employee cohabitates; and
      c. Who represent themselves to the community as married to each other; and
      d. There is no legal impediment to the marriage.

B. **Current Domestic Partner** means an adult
   1. Who is at least 18 years of age; and
   2. Who is of the same gender as the Employee; and
   3. With whom the Employee has shared an exclusive, committed relationship for at least one year prior to enrollment with the intent for the relationship to last indefinitely; and
   4. Who is not related to the Employee by blood to a degree that would prohibit marriage; and
   5. Neither the Employee nor partner is married to another person; and
   6. Neither the Employee nor partner is in a civil union with another person.

C. **Current partner in a civil union** means an adult, regardless of the gender of either party
   1. At least 18 years of age;
   2. Who is not a partner in another civil union;
   3. Who is not married to another person;
   4. Who is not under guardianship, unless the partner under guardianship has the written consent of his or her guardian; and
   5. Neither partner is a relative of the other whether the relationship is by the half or the whole blood.

D. A **child** through the end of the month in which the child turns age 26. The legal definition of child must be applied (e.g., first generation, parent-child relationship). As of July 1, 2011, marital status, student status, financial support, and residency are no longer factors under the Patient Protection and Affordable Care Act.

   A child includes:
   a. a biological or natural child;
   b. a legally adopted child;
   c. a child legally placed for adoption or foster care;
   d. a step child as long as the employee and natural parent are married;
   e. a child of a same-gender domestic partner or a partner in a civil union as long as the employee and parent are in a committed relationship; and

f. a child for whom the employee has a court order granting legal custody or parental responsibility that specifies the employee is responsible for providing health insurance coverage.

A physically or mentally **disabled child** who is 26 years of age or older and is

a. unmarried;
b. certified by the State's medical carrier or third-party administrator as being disabled **prior** to the age of 26 (proof of disability and dependency must be provided prior to becoming covered under the medical plan and annually, if requested);
c. not covered by any other government programs; and
d. relying on the employee as the major source of financial support or the employee is directed by a court order to provide coverage.

Exclusions

Ex-spouses and their children, same-gender domestic ex-partners and their children, civil union ex-partners and their children, opposite-gender domestic partners and their children, parents, grandparents and grandchildren, siblings, aunts and uncles, nieces and nephews, cousins, and any other relatives or non-relatives in the household. The only exception is when a court determines a qualified dependent relationship exists and issues an order specifying responsibility for coverage.

KAISER PERMANENTE®

KAISER FOUNDATION HEALTH PLAN OF COLORADO

Summary of 2014 Benefit Changes

Large Group/Non-Medicare

HSA-Compatible Deductible HMO

(*Effective upon Renewal on or after January 1, 2014)*

CLARIFICATIONS

Port Wine Stains. Treatment of congenital hemangioma (port wine stains) will no longer be limited to members under the age of 19 or to the face and neck.

Women's Preventive Services. Routine prenatal and postnatal visits are not included in the required coverage for women's preventive services under the Affordable Care Act.

BASE PLAN CHANGES

Home Health Care. The special services program for hospice-eligible members will cover unlimited home health visits.

Specialty Drug Tier. The formulary for the prescription drug benefit's specialty drug tier is changing to include other specialty drugs in addition to self-injectibles for grandfathered plans only.

CHANGES DUE TO LEGISLATION

Out of Area Student Benefit. The out-of-area student benefit will cover up to 5 office visits, 5 diagnostic x-rays, and 5 prescription drug refills.

Applied Behavioral Analysis. Applied behavioral analysis for the treatment of autism spectrum disorders will be provided as follows:

- Up to 550 visits per year for children ages 0-8
- Up to 185 visits per year for children ages 9-18

Early Intervention Services. Early intervention services for eligible children will be provided up to the maximum number of visits as determined by the State.

Over the Counter Items (OTC). Certain OTC items as required by the ACA will be covered at $0 cost share when determined to be clinically appropriate for non-grandfathered plans and for grandfathered plans with HCR prevention benefits.

BRCA Testing & Counseling. When determined to be clinically appropriate, BRCA testing and counseling will be covered at $0 cost share for non-grandfathered plans and for grandfathered plans with HCR prevention benefits.

CONTACT US

Advice Nurses

CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**: 970-207-7171** or call toll-free **1-800-218-1059**
TTY	***Denver/Boulder*** Members**: 303-338-4428** ***Southern Colorado*** Members: **1-866-635-7550** ***Northern Colorado*** Members***:*** **1-866-635-7550** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

After-Hours Medical Needs

CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	***Denver/Boulder*** Members**: 303-338-4428** ***Southern Colorado*** Members: **1-866-635-7550** ***Northern Colorado*** Members: **1-866-635-7550** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Appeals Program

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

Binding Arbitration

CALL	**Quality, Risk, and Patient Safety 303-344-7298**

Claims Department

CALL	***Denver/Boulder*** Members: **303-338-3600** or toll-free **1-800-382-4661** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-382-4661**
TTY	**1-800-521-4874** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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

Member Services

CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700**
TTY	**1-800-521-4874** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**www.kp.org**

Membership Administration

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

Patient Financial Services

CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700**
TTY	**303-338-3820** or toll-free **1-800-659-2656** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

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

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SCHEDULE OF BENEFITS (WHO PAYS WHAT)

I. ELIGIBILITY

A. Who Is Eligible

1. General

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

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser Foundation Health Plan or allied plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, 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 over the dependent limiting age but under the dependent student limiting age as specified in the "Schedule of Benefits (Who Pays What)" who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

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

4. Medicare Eligibility

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

5. Health Savings Account Eligibility

Enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be: (a) covered by another health coverage plan (for example, through your spouse's employer) that is not also an HSA-compatible health plan, with certain exceptions; (b) enrolled in Medicare; or (c) able to be claimed as a Dependent on another person's tax return. Consult your tax advisor for more information about your eligibility for an HSA.

B. Enrollment and Effective Date of Coverage

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

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

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

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

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

   a. For newborn children, the moment of birth. A newborn child is automatically covered for the first 31 days.
      For existing Subscribers:
      i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
      ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.
   b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
      For existing Subscribers:
      i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
      ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.
   c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment Due to Loss of Other Coverage" below.

4. Special Enrollment Due to Loss of Other Coverage
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after the enrolling persons lose other coverage, if:

   The enrolling persons had other coverage when you previously declined all coverage through your Group (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason); and the loss of the other coverage is due to one of the following:
   a. Exhaustion of COBRA coverage.
   b. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment, in the following situations:
      i. termination of employer contributions for non-COBRA coverage;
      ii. loss of coverage under other creditable coverage as a result of termination of employment or eligibility;
      iii. reduction in the number of hours of employment;
      iv. the involuntary termination of the creditable coverage;
      v. death of a spouse, legal separation or divorce;
      vi. reaching the age limit for dependent children;
      vii. Subscriber's death;
      viii. a dependent is disenrolled from or otherwise becomes ineligible for Children's Basic Health Plan (application for enrollment must be made no later than 90 days after disenrollment);

ix. the enrolling person loses eligibility for Medicaid, but not due to termination for cause (application for enrollment must be made no later than 60 days after loss of coverage);
x. the individual becomes eligible to receive premium assistance under Medicaid or Children's Basic Health Plan (application for enrollment must be made no later than 60 days after eligibility determination for premium assistance);
xi. the individual has reached a lifetime maximum on all benefits; or
xii. the individual has lost coverage as a result of moving out of the plan's service area.

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

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

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

6. Other Special Enrollment Events (applies to non-grandfathered health plans only)
You may enroll as a Subscriber (along with any eligible Dependents) and existing Subscribers may add eligible Dependents if any of the following would, but for any continuation coverage, result in the loss of coverage:

a. Per the federal Affordable Care Act:
   i. You lose employment for a reason other than gross misconduct.
   ii. Your employment hours are reduced.
   iii. You are a Dependent of someone who becomes entitled to Medicare.
   iv. You become divorced or legally separated.
   v. You are a Dependent of someone who dies.
   vi. Connect for Health Colorado determines that one of the following occurred because of misconduct on the part of a non-Connect for Health Colorado entity that provided enrollment assistance or conducted enrollment activities:
      1. A qualified individual was not enrolled in a qualified health plan.
      2. A qualified individual was not enrolled in the qualified health plan that the individual selected.
      3. A qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost sharing reductions.
b. Per Colorado law:
   i. You lose coverage due to the death of a covered employee, the termination or reduction in number of hours of the covered employee's employment, or the covered employee becoming eligible for Medicare.
   ii. You lose coverage due to the divorce or legal separation of the covered employee from the covered employee's spouse or partner in a civil union.
   iii. You become a dependent of a covered person through marriage, civil union, birth, adoption, or placement for adoption, by entering into a designated beneficiary agreement pursuant to the Colorado Designated Beneficiary Agreement Act, or pursuant to a court or administrative order mandating that you be covered.
   iv. You lose other creditable coverage due to the termination of your employment or eligibility for the coverage, reduction in number of hours of employment, involuntary termination of coverage, or reduction or elimination of your employer's contributions toward coverage.
   v. You lose coverage under the ColoradoMedical Assistance Act (Medicaid) and then request coverage under an employer's group health benefit plan within sixty (60) days of the loss of coverage.
   vi. You or your dependent becomes eligible for premium assistance under the Colorado Medical Assistance Act (Medicaid) or the Children's Basic Health Plan.
   vii. A parent or legal guardian dis-enrolls a dependent, or a dependent becomes ineligible for the Children's Basic Health Plan, and the parent or legal guardian requests enrollment of the dependent in a health benefit plan within sixty (60) days of the disenrollment or determination of ineligibility.
   viii. You have another event that is defined as a qualifying event by regulations promulgated by the Colorado Division of Insurance.
c. You must submit a Health Plan approved enrollment application to Health Plan:
   i. Within sixty (60) days after you lost coverage under the Colorado Medical Assistance Act (Medicaid) and then requested coverage under an employer's plan within sixty (60) days of loss of coverage; and when an employee or dependent becomes eligible for premium assistance under the Colorado Medical Assistance Act (Medicaid) or the Children's Basic Health Plan.
   ii. Within 30 (thirty) days of the loss of other coverage or the qualifying event. .
d. Membership becomes effective:

i. in the case of birth, adoption, or placement for adoption, on the date of the event.
ii. in the case of marriage, civil union, or other qualifying events, coverage must be effective on the first day of the following month after the date Health Plan receives a completed enrollment application.

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet one of the requirements stated above.

7. 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.

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

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

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

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

A. Your Primary Care Plan Physician

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

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

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

b. ***Southern*** and ***Northern Colorado*** Service Areas
You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

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

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

If you are seeking routine or specialty care in any ***Denver/Boulder*** Plan Hospital, you must have a referral from your local PCP. If you do not get a referral, you will be billed for the full amount of the office visit Charges. If you are visiting in the ***Denver/Boulder*** Service Area and need after-hours or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below.

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

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

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

B. Getting a Referral

1. Referrals

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

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

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

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

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

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

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

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

2. Specialty Self-Referrals

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

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

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

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

A self-referral provides coverage for routine visits only. Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Plan Physician

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

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

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

C. Plan Facilities

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

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

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to *www.kp.org*, click on "Locate our services" then "Facility directory."

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

D. Getting the Care You Need

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

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office hours. Your office visit Charge, as defined in the "Schedule of Benefits (Who Pays What)," will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after-hours Plan Facilities. The Charge for non-emergency, non-routine care received in Plan Facilities after regular office hours listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

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

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

E. Out-of-Area Student Benefit

A limited benefit is available to Dependents who are full-time students attending an accredited college, vocational or boarding school outside any Kaiser Foundation Health Plan service area. The Out-of-Area Student Benefit applies to office visits, diagnostic X-rays, and prescription drug fills as covered under this EOC. Office visits are limited to primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, prevention, and allergy injections. It does not include special procedures such as CT, PET, MRI, or nuclear medicine. See the "Schedule of Benefits (Who Pays What)."

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

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

Exclusions and Limitations:

1. Services received outside the United States are not covered.
2. Transplant Services are not covered.
3. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services, Non-emergency, Non-Routine Care) are not covered under the Out-of-Area Student Benefit.

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

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser Foundation Health Plan or allied plan service area in order to receive covered Services (except out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care).

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

H. Cross Market Access

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

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

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

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:

- A Plan Physician determines that the Services are Medically Necessary to prevent, diagnose or treat your medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health.
- The Services are provided, prescribed, authorized or directed by a Plan Physician. This does not apply where specifically noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and (b) "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care".

- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Getting a Referral" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care".
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations and Reductions" section.

Note: Deductibles, Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)."

A. Outpatient Care

Outpatient Care 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 outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility or at home:

1. Primary care visits: Services from family medicine, internal medicine and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by a Plan Physician.
9. Medical social Services.
10. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).

B. 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 a Plan Physician determines it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. 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 his/her own Copayments and/or Deductibles requirements.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.
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. Bariatric surgery and cosmetic surgery related to bariatric surgery.

C. Ambulance Services

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

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

D. Chemical Dependency Services

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

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

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

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

   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 as determined by a Plan Physician 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 below.

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

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

We cover Services you receive in connection with a clinical trial if all of the following conditions are met:

1. We would have covered the Services if they were not related to a clinical trial.
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination.
   b. You provide us with medical and scientific information establishing this determination.
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      vii. The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
         1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.

2. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the applicable cost share 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 cost share that applies to hospital inpatient care.

Clinical trials exclusions:
1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

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

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

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

G. Drugs, Supplies and Supplements

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

In any year, you must pay full Charges for all drugs until you meet your Deductible. After you meet your Deductible, you pay the applicable Copayment or Coinsurance for these drugs for the rest of the year, subject to the annual Out-of-Pocket Maximum limits.

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

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

   b. Outpatient Prescription Drugs
   Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." If your prescription drug Copayment shown on the "Schedule of Benefits (Who Pays What)" exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

   c. Administered Drugs
   If the following are administered (1) during a covered stay in a Plan Hospital or Skilled Nursing Facility, or (2) in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What):"

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

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

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

f. Food Supplements
Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

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

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

2. Limitations***:***
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. ***Denver/Boulder*** Service Area: Compound medications are covered as long as they are on the compounding formulary.
   c. ***Southern*** and ***Northern Colorado*** Service Areas: Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.
3. Drugs, Supplies and Supplements Exclusions***:***
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "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)."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
   l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. (***Denver/Boulder*** Members only).
   m. Prescription drugs necessary for Services excluded under this Evidence of Coverage.

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.

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

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
   b. Durable Medical Equipment Exclusions:
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost equipment.
      iii. Repair, adjustments or replacements necessitated by misuse.
      iv. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.
2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a 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 accord with this EOC. Including repairs and replacements, of such prosthetic devices.
      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."
   b. Prosthetic Devices Exclusions:
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.
3. Orthotic Devices
   Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

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 Early Intervention Services (EIS) up to the maximum number of visits as determined by the State. EIS are subject to the Deductible and apply toward the Out-of-Pocket Maximum. EIS are not subject to any Copayments or Coinsurance.

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

2. Limitations
   The maximum number of visits does not apply to:
   a. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical condition; or
   b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Act"; or
   c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.
3. Early Childhood Intervention Services Exclusions:
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination, as defined by State or federal law; and
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this Evidence of Coverage.

J. Emergency Services and Non-Emergency, Non-Routine Care

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

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

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

   a. **Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)**

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

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

      i. We cover out-of-Plan Emergency Services as follows:
         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis or premature delivery.
         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

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

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

   b. Emergency Services Exclusions:

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

infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

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

2. Non-Emergency, Non-Routine Care

a. Non-Emergency, Non-Routine Care Provided by Plan Providers

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

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

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

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

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

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

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

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

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

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

There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside our Service Area. Non-emergency, non-routine care received from non-Plan Providers is covered only when obtained outside our Service Area, if all of the following requirements are met:

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

3. Payment

a. Health Plan's payment for covered out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

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

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

b. Our payment is reduced by:

i. the Copayment and/or Coinsurance for Emergency Services and Special Procedures performed in the emergency room. The emergency room and Special Procedures Copayment, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. Coordination of benefits; and
iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and
v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
vi. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: The procedure for receiving reimbursement for out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

K. Family Planning Services

We cover the following:

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

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

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

L. Hearing Services

1. Persons Under the Age of 18 Years

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

2. Persons Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."
   b. Hearing Services Exclusions:
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

M. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only if you are confined to your home; and
   d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by Health Plan on a case-by-case basis.

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

2. Home Health Care Exclusions:
   a. Custodial care.

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

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

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

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

N. Hospice Care

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

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

We cover the following Services and other Benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

a. Physician care.
b. Nursing care.
c. Physical, occupational, speech and respiratory therapy.
d. Medical social Services.
e. Home health aide and homemaker Services.
f. Medical supplies, drugs, biologicals and appliances.
g. Palliative drugs in accord with our drug formulary guidelines.
h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
i. Counseling and bereavement Services.
j. Services of volunteers.

O. Infertility Services

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

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

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; and psychiatrically oriented child and teenage guidance counseling.

Visits for the purpose of monitoring drug therapy are covered.

Psychological testing as part of diagnostic evaluation is covered.

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

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

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

We cover mental health services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician 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 a Plan Physician determines such evaluation to be Medically Necessary.
   b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.
   c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.
   d. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
   e. Services which are custodial or residential in nature.

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

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

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

   c. Multidisciplinary Rehabilitation Services
   If, in the judgment of a Plan Physician, significant improvement in function is achievable within a two-month period, we will cover treatment for up 60 days per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. After your Deductible has been met, we cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

   d. Pulmonary Rehabilitation
   We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational and speech therapy Coinsurance. Clinical criteria are used to determine appropriate candidacy for the program, which consists of: an initial evaluation; up to six (6) education sessions; up to twelve exercise sessions; and a final evaluation to be completed within a two to three-month period. See the "Schedule of Benefits (Who Pays What)."

   e. Therapies for Congenital Defects and Birth Abnormalities
   After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per year for each physical, occupational and speech therapy. Such visits shall be distributed as Medically Necessary throughout the year without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "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 children under the age of 19, we cover the following therapies for the treatment of Autism Spectrum Disorders:
      i. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by a Plan Physician as Medically Necessary. See the "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, up to the maximum benefit permitted by State law. See the "Schedule of Benefits (Who Pays What)."

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

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

R. Preventive Care Services

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

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

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

S. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma 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.

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

T. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products and their administration.

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

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

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

U. Transplant Services

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

b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.
c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.

2. Related Prescription Drugs
Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance shown on the "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 accord with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.
b. Plan Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.
c. A Plan Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.
d. After referral, if a Plan Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations:
a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
b. Non-human and artificial organs and their implantation are excluded.
c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" 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. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

V. Vision Services

1. Coverage
We cover wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

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

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

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

W. X-ray, Laboratory and Special Procedures

1. Coverage
a. Outpatient
We cover the following Services:
i. Diagnostic X-ray and laboratory tests, Services and materials, including isotopes, electrocardiograms, electroencephalograms and mammograms

ii. Therapeutic X-ray Services and materials
iii. Special procedures such as MRI, CT, PET and nuclear medicine. **Note:** Members will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. The Member is responsible for any applicable Copayment or Coinsurance for Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.

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

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

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:
   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. All chiropractic Services and supplies that are not covered under other benefits.
   See the "Schedule of Benefits (Who Pays What)."
2. **Bariatric Surgery and Cosmetic Surgery Related to Bariatric Surgery.**
3. **Certain Exams and Services.** Physical exams and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
   a. employment;
   b. participation in employee programs;
   c. insurance;
   d. Disability;
   e. licensing; or
   f. on court order or for parole or probation.
4. **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.
5. **Custodial Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.
6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma and, unless otherwise specified herein, (a) and (b) are received at a Plan Hospital, Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.
7. **Directed Blood Donations.**
8. **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.

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

11. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.
12. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased supplemental coverage.
13. **Intermediate Care.** Care in an intermediate care facility.
14. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

15. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or out-of-Plan non-emergency, non-routine care.
16. **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.
17. **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.
18. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services as described under "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section. Travel and lodging expenses are not covered for Members who are referred to a non-Plan Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.
19. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not 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.
20. **Weight Management Facilities.** Services received in a weight management facility.
21. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

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

C. Reductions

1. Coordination of Benefits (COB)

   The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines 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 below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

   DEFINITIONS

   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, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

ii. "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies and coverage under other 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. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

c. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.
ii. If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
iii. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.
v. The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions and precertification of admissions.

d. "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.

e. "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.

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

ORDER-OF-BENEFIT DETERMINATION RULES

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

a. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

b. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

d. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

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

ii. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

B. If the specific terms of a court decree state that one of the parents is responsible for the 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 claim determination periods or plan years commencing after the plan is given notice of the court decree.

C. If the parents are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

iii. Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled d. i. above.

iv. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

v. Longer or shorter length of coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

vi. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

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 claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

i. Determine its obligation to pay or provide benefits under its contract;
ii. Determine whether a benefit reserve has been recorded for the covered person; and
iii. Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

b. If a covered person is enrolled in two or more closed panel plans the following coordination of benefits rules will apply:

i. COB does not occur if the enrollee did not go to either plan's closed panel, unless there is a covered benefit (i.e. medical emergency, etc.).
ii. The two plans will coordinate benefits for covered services that are covered services for both plans (i.e. emergency services, services from providers that are participating in both plans, etc.).
iii. If the covered person goes to the primary plan's closed panel providers for covered services, the secondary carrier shall coordinate benefits only to the extent that there are benefits or reserves available.
iv. If the primary closed panel has no liability because the covered person did not use the closed panel providers, but the covered person used the secondary closed panel providers, the secondary plan will pay benefits as though they are primary.

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 it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. 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 it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another plan may include an amount that should have been paid under this plan. If it does, we 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. We 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, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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

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 Non-Emergency, Non-Routine 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.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

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

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Physicians have telephone access to interpreters in over 150 foreign languages.

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

C. 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. Binding Arbitration

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

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

K. 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.

L. Contracts with Plan Providers

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

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

M. Deductible Takeover Credit

Deductible takeover is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

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

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

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

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

You must submit all claims for Deductible takeover credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department**. To get a copy of the Prior Carrier Information Cover Form, please call **Claims Customer Service.**

N. Governing Law

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

O. Group and Members not Health Plan's Agents

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

P. 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.

Q. 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.

R. 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.

S. 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.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

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

U. Value-Added Services

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

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

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

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

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as deductible or out-of-pocket maximum.

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

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

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

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

V. Women's Health and Cancer Rights Act

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

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. 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 Section I, 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.

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:

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

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

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

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

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six

(6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Dues to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

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

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

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

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

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

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

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

H. Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from 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), 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 below in this "Appeals and Complaints" section.

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

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

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

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

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

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(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
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 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 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 claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then 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 3 days after receiving your claim.

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

b. Non-Urgent Concurrent Care Appeal

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

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

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

c. Urgent Concurrent Care Appeal

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

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

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

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

a. Post-Service Claim
Within 180 days from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after 180 days from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim 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)
We may terminate your membership retroactively (see Rescission of Membership under Section VIII. Termination/Nonrenewal/Continuation). 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 the **Member Services Call Center** at **1-866-846-2650**.

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 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.

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

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

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

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting.

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

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

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

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

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

External Review

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

You have the right to request an independent external review of our decision, if our decision involves an adverse benefit determination involving 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 another copy of this form) to the **Appeals Program** within 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 3 days after the date on which our notice was drafted, unless you can prove that you received our notice after the 3 day period ends.
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 another copy of this form).

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

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).

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 significantly 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 appealing the denial to the Division of Insurance. At the same time that we send this notice to you, we will send a copy of it to the Division of Insurance.

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

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

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision 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.

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:

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

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

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

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

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

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

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

Dues: Periodic membership charges paid by Group.

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

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

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

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

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions

made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan (HDHP): A health benefit plan that meets the requirements of Section 223 (c)(2) of the Internal Revenue Code. The health care coverage under this EOC has been designed to be a High Deductible Health Plan compatible for use with a Health Savings Account.

Kaiser Permanente: Health Plan and Medical Group

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

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

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

Out-of-Pocket Maximum: The annual limit to the total amount of Coinsurance you must pay in a year for covered Services, as described in the "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. 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, 80295, 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, 80513, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80623, 80640, 80642, 80643. Subscribers residing in zip code 80513 also have access to the ***Northern Colorado*** Service Area except for pharmacy Services. Pharmacy Services are only available at a Kaiser Permanente pharmacy.

The ***Northern Colorado*** Service Area is that portion of Adams, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 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, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80943, 80944, 80945, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 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 p lan.

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).

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

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SCHEDULE OF BENEFITS
(formerly SUMMARY CHART)

Benefits for State of Colorado

Group #225 – T12, T13, T14, T15, T16, T17, T24, T25, T26, T27, T30, T31

This Schedule of Benefits discusses:

I. **DEDUCTIBLES (if applicable)**

II. **ANNUAL OUT-OF-POCKET MAXIMUMS**

III. **COPAYMENTS AND COINSURANCE**

IV. **DEPENDENT LIMITING AGE**

V. **DEPENDENT STUDENT LIMITING AGE**

This Schedule of Benefits does not fully describe benefits. For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits. Please refer to the identical heading in the "Benefits/Coverage (What is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC. Here is some important information to keep in mind as you read this Schedule of Benefits:

- The Deductibles, Copayments or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan.
- 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.
- In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
- You will 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.
- 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.
- 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.
- For items ordered in advance, you pay the Deductibles, Copayments or Coinsurance in effect on the order date.
- You, as the Subscriber, are responsible for any Deductibles, Copayments and/or Coinsurance, incurred by your Dependents enrolled in the Plan.
- Annual dollar, day and visit limits, Deductibles and Out-of-Pocket Maximums are based on a contract year.

I. DEDUCTIBLES

A. The following Deductibles apply under your plan:

Aggregate Deductible

$1,250/Individual per year
$2,500/Family per year

The Deductible represents the full amount you must pay for certain covered Services before any Copayment or Coinsurance applies.

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

1. For covered Services that **ARE** subject to the Deductible:
   a. You must pay full charges for covered Services until your Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the Deductible.
   b. Once you have met your Deductible for the year, you will then pay, for the rest of the year, your applicable Copayment or Coinsurance for those covered Services subject to the Deductible. See "III. Copayments and Coinsurance."
   c. Your applicable Copayment and Coinsurance may apply to your annual Out-of-Pocket Maximum. Please see "II. Annual Out-of-Pocket Maximums."

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

C. Individual and Family Deductibles:
   1. **Aggregate Deductible:**
      a. The individual Deductible only applies for self only coverage.
      b. For two or more Members, there is no individual Deductible.
      c. After the family Deductible is met, all covered family Members will pay Copayments or Coinsurance for most covered Services for the rest of the year.
   2. **Embedded Deductible:**
      a. Each individual family Member has his or her own Deductible.
      b. If a family Member reaches his or her individual Deductible before the family deductible is met, they will begin paying Copayments or Coinsurance for most covered Services for the rest of the year before the rest of the family.
      c. The entire family as a whole has a cumulative family Deductible. After the family Deductible is met, they will begin paying Copayments or Coinsurance for most covered Services for the rest of the year. This is true even for those who have not met their individual Deductibles.

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The following Out-of-Pocket Maximums (OPM) amounts apply under your plan:

Aggregate OPM:

$2,500/Individual per year
$5,000/Family per year

The OPM limits the total amount you must pay during the year for certain covered Services. Covered Services may or may not apply to the OPM. It depends on the plan your Group has purchased.

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

A. Your Deductible applies to the OPM. See "I. Deductibles."

B. For covered Services that **APPLY** to the OPM.
   1. The only Copayments or Coinsurance that apply toward the OPM are those made for covered Services listed as applying to the OPM. Please see "III. Copayments and Coinsurance."
   2. Once your OPM is met, you will no longer pay for those covered Services that apply to the OPM.

C. For covered Services that do **NOT APPLY** to the OPM.
   Your Copayment or Coinsurance will always apply. See "III. Copayments and Coinsurance."

D. Individual and Family OPM
   1. **Aggregate OPM:**
      a. The individual OPM only applies for self only coverage.
      b. For two or more Members, there is no individual OPM.
      c. The entire family as a whole has a cumulative family OPM, which the family must collectively meet.
      d. After the family OPM is met, all covered family Members will pay Copayments or Coinsurance for most covered Services for the rest of the year.
   2. **Embedded OPM:**
      a. Each individual family Member has his or her own OPM.

b. If a family Member reaches his or her individual OPM before the family OPM is met, all covered family Members will pay Copayments or Coinsurance for most covered Services for the rest of the year. Even those who have not met their individual OPM.
c. The entire family as a whole has a cumulative family OPM. After the family OPM is met, all covered family Members will pay Copayments or Coinsurance for most covered Services for the rest of the year. This is true even those who have not met their individual OPM.

Tracking Deductibles and Out-of-Pocket Amounts
Once you have received Services and we have processed the claim for Services rendered, you will receive an Explanation of Benefits (EOB) from us. The EOB will list the Services you received, the cost of those Services and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your Deductible and/or OPM.

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

III. COPAYMENTS AND COINSURANCE

Outpatient Care	You Pay
Primary care visits *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Specialty care visits *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Consultations with clinical pharmacists *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Allergy injections *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Allergy evaluation and testing *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Gynecology care visits *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Routine prenatal and postpartum visits *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Outpatient surgery at designated outpatient facilities *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Covered Services not otherwise listed in this Summary Chart received during an office visit, a scheduled procedure visit, or provided by a Plan Medical Office *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance

Hospital Inpatient Care	You Pay
(Subject to Deductible; Applies to Out-of-Pocket Maximum)	10% Coinsurance
(See III. "Benefits/Coverage (What is Covered)", B. "Hospital Inpatient Care", in this EOC for the list of covered Services)	Excludes bariatric surgery
Inpatient professional visits (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance

Ambulance Services	You Pay
(Subject to Deductible; Applies to Out-of-Pocket Maximum)	10% Coinsurance

Chemical Dependency Services	You Pay
Inpatient medical detoxification (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Inpatient professional visits for medical detoxification (*Subject to Deductible; Applies toward Out-of-Pocket Maximum*)	10% Coinsurance
Outpatient Services – individual or group (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance including partial hospitalization
Residential rehabilitation (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance

Complementary and Alternative Medicine	You Pay
Chiropractic Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Acupuncture Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Dialysis Care	You Pay
(Subject to Deductible; Applies to Out-of-Pocket Maximum)	10% Coinsurance

Drugs, Supplies and Supplements	You Pay
Office-administered drugs (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
• Travel immunizations	Not Covered
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the Deductible and apply to the Out-of-Pocket Maximum except as otherwise listed in this "Drugs, Supplies and Supplements" section.)*	$10 Generic/$40 Brand name Tobacco cessation and contraceptive drugs at No Charge; Not subject to Deductible.
• Pharmacy Deductible	Not Applicable
• Infertility drugs	Not Covered
• Over the counter items (OTC): *(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to Deductible)*	No Charge
• Prescribed supplies	20% Coinsurance
• Sexual dysfunction drugs	Not Covered
• Specialty drugs	20% Coinsurance up to $100 per drug dispensed Insulin @ applicable Copayment/Coinsurance
	Supply Limit
Day supply limit	30 days
Mail-order supply limit	90 days @ 2 Copayments See Additional Provisions

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
	Annual Maximum Benefit
Annual maximum benefit paid by Health Plan	Not Applicable
	You Pay
Durable medical equipment *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Breast pumps *(**If covered**, must be obtained within 6 months (180 days) following delivery; Not subject to Deductible; Applies to Out-of-Pocket Maximum)*	No charge
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Hospital Inpatient Care" and "Outpatient Care" for Deductible and Out-of-Pocket Maximum information)*	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment(s) and/or Coinsurance
• Prosthetic arm or leg *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
• All other prosthetic devices *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Orthotic devices *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Oxygen *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance See Additional Provisions

Emergency Services and Non-Emergency, Non-Routine Care	You Pay
Plan and non-plan emergency rooms (covered 24 hours a day) (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Non-emergency, non-routine visits at Plan Facilities after regular office hours *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Covered Services received during after-hour visits to Plan Facilities *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance

Family Planning Services	You Pay
Family planning counseling *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Associated outpatient surgery procedures	See "Outpatient Care" for applicable Copayment or Coinsurance

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Hearing aids for persons under the age of 18 (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
	Credit
Hearing aids for persons age 18 and over (*Not subject to Deductible; Does not apply to Out-of-Pocket Maximum*)	Not Covered

Home Health Care	You Pay
Health Services provided in your home and prescribed by a Plan Physician (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Special Services program For hospice-eligible Members who have not yet elected hospice care *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance

Hospice Care	You Pay
Hospice care for terminally ill patients (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance

Infertility Services	You Pay
All covered Services related to the diagnosis and treatment of infertility *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Artificial insemination, including associated X-ray and laboratory Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Mental Health Services	You Pay
Outpatient individual or group therapy *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance including partial hospitalization
Inpatient psychiatric hospitalization (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
• Inpatient day limit	Not Applicable
Inpatient professional visits (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance

Out-Of-Area Student	You Pay
• Outpatient office visits (Combined visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, prevention, and allergy injections) *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance (10% Coinsurance for covered services received during a visit) Limited to 5 visits per year
• Diagnostic X-ray Services *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per year
• Outpatient Prescription Drugs *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	Limited to 5 prescription drug fills per year See "Drugs, Supplies and Supplements" for applicable Copayment or Coinsurance

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient professional physical, occupational and speech therapy Services (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Short-term outpatient physical, occupational and speech therapy visits *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance Up to 20 visits per therapy per year
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance Up to 60 days per condition per year
Therapies for the treatment of Autism Spectrum Disorders (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	
• Outpatient physical, occupational and speech therapy visits	10% Coinsurance
• Applied Behavioral Analysis	10% Coinsurance
• Annual benefit maximum for children ages 0-8	917 visits/year
• Annual benefit maximum for children ages 9-18	308 visits/year

Preventive Care Services	You Pay
• Preventive Care Visits (Not subject to Deductible; Applies to Out-of-Pocket Maximum) • Adult preventive care exams • Well-woman care exams • Immunizations	No Charge
• Colorectal Cancer Screenings *(Not subject to Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
• Adult preventive care screenings *(Not subject to Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Well-woman care screenings *(Not subject to Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Well-child care *(Not subject to Deductible; Applies to Out-of-Pocket Maximum)*	No Charge for children through age 17

Reconstructive Surgery	You Pay
	See "Outpatient Care" and "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Skilled Nursing Facility Care	You Pay
(*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance Up to 100 days per year

Transplant Services	You Pay
Transplant Services *(See "Hospital Inpatient Care" and "Outpatient Care" for Deductible and Out-of-Pocket Maximum information)*	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance
Inpatient professional visits *(See "Hospital Inpatient Care" for Deductible and Out-of-Pocket Maximum information)*	See "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	You Pay
Eye refraction exams when performed by an Optometrist (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Eye refraction exams when performed by an Ophthalmologist (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Optical Hardware *(Not subject to Deductible; Applies to Out-of-Pocket Maximum)*	**Credit** $150 Credit every 24 months See Additional Provisions

X-Ray, Laboratory and Special Procedures	You Pay
Diagnostic laboratory Services (*Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Diagnostic X-ray Services (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance
Therapeutic X-ray Services *(Subject to Deductible; Applies to Out-of-Pocket Maximum)*	10% Coinsurance
Special procedures such as CT, PET, MRI, nuclear medicine (*Subject to Deductible; Applies to Out-of-Pocket Maximum*)	10% Coinsurance

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section 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.

V. DEPENDENT STUDENT LIMITING AGE

The Dependent student limiting age as described under Dependents in the "Eligibility" section is the end of the month in which age 26 is reached.

Additional Provisions

If your Group has purchased additional coverage, please see “Additional Provisions” for more information.

ADDITIONAL PROVISIONS

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

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-gender domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility and Enrollment" section of this Evidence of Coverage; 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.

DOMP0AA (01-12)

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 "Summary Chart" 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. You will be charged as a non-Member for items of DME, prosthetics and orthotics until your Deductible is met, if applicable.

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 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. Oxygen and oxygen dispensing equipment. (Please see the oxygen benefit description for more details regarding your oxygen benefit description.)
      iv. 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 in newborn Members are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and 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 in newborn Members, as described above.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost prosthetic devices.
      vi. Repairs, adjustments or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
      Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions:
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate for newborn Members 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 (01-14)

OPTICAL BENEFIT

A credit, as shown in the "Vision Services" section of the "Summary Chart," applies toward the purchase of one pair of: (i) regular lenses; (ii) frames; or (iii) contact lenses, including cosmetic lenses, when obtained at a Plan Medical Office and prescribed by a Plan Physician or a Plan Optometrist (or a non-plan provider for **eyeglasses only**).

Covered Services include:

1. The frame;
2. Mounting of lenses in the frames; and
3. The original fitting and subsequent adjustment of the frame.

The credit must be used at the initial point of sale.

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

EXCLUSION: Replacement of lost or broken lenses or frames.

OPT0AA (01-12)

OXYGEN AND OXYGEN EQUIPMENT

Oxygen and oxygen dispensing equipment used in the Member's home is covered in the Service Area as shown on the "Summary Chart." A Member's home includes an institution used as his or her home.

Oxygen refills are covered when a Member is temporarily traveling outside the Service Area. This applies only if the Member: (1) has an existing oxygen order; and (2) obtains refills from Health Plan's designated oxygen vendor.

OXYG0AA (01-12)

ELECTIVE ABORTION EXCLUSION

Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are:

1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or
2. When the pregnancy is the result of an act of rape or incest; or
3. Treatment of complications following an abortion.

TABS0AA (01-12)

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.

Coverage includes, but 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 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 Plan Physician.
3. Cervical cancer screening.
4. Breast cancer screening.
5. Cholesterol screening.
6. Colorectal cancer screening.
7. Immunizations pursuant to the schedule established by the ACIP.
8. Tobacco use screening of adults and tobacco cessation interventions by your Primary Care Plan Physician.
9. Type 2 diabetes screening for adults with high blood pressure.
10. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
11. Prostate Cancer screening.
12. Cervical cancer vaccines.

"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. www.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 www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.

PV0AA (01-14)

PRESCRIPTION DRUG BENEFIT INFORMATION FOR DENVER/BOULDER AND NORTHERN COLORADO MEMBERS

PRESCRIPTION DRUG BENEFIT
(HSA-Qualified Deductible HMO Plan)

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 Formularies. The term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formularies.

Please refer to the "Summary Chart" 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; and a tier for prescribed non-preferred drugs authorized through the non-preferred drug process.

   In any calendar year, you must pay full Charges for prescription drugs until you meet your Deductible. After you meet your Deductible you pay the applicable Copayment or Coinsurance for prescription drugs for the rest of the calendar year. Your cost share is subject to the Annual Out-of-Pocket Maximum.

   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.

   Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Coinsurance.

   Contraceptive drugs and devices:
   a. For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Summary Chart."

   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:
   a. Available in the United States only from a single manufacturer; and
   b. Not listed as generic in the then-current commercially available drug database(s) Health Plan subscribes to;

   are provided at the brand-name Copayment. 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; or
   b. Physician to whom a Member has been referred by a Plan Physician; or
   c. Dentist (when prescribed for acute conditions); and

   are 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 a Member requests a brand-name drug when

a generic equivalent drug is the preferred product, the Member must pay the brand-name Copayment, plus any difference in price between the preferred generic equivalent drug prescribed or authorized by the Plan Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, the Member pays only the brand-name Copayment.

b. Insulin.
c. Compounded medications as long as they are on the compounding formulary.

2. Drugs, Supplies and Supplements Exclusions:
   a. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   b. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   c. Drugs and injections for the treatment of sexual dysfunction.
   d. Drugs or injections for treatment of involuntary infertility.
   e. Drugs to shorten the length of the common cold.
   f. Drugs to enhance athletic performance.
   g. Drugs available over the counter and by prescription for the same strength.
   h. Drugs for the treatment of weight control.
   i. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   j. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   k. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.

PRESCRIPTION DRUG BENEFIT INFORMATION FOR SOUTHERN COLORADO MEMBERS

PRESCRIPTION DRUG BENEFIT
(HSA-Qualified Deductible HMO Plan)

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 Formularies. The term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formularies.

Please refer to the "Summary Chart" 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; and a tier for prescribed non-preferred drugs authorized through the non-preferred drug process.

   In any calendar year, you must pay full Charges for prescription drugs until you meet your Deductible. After you meet your Deductible you pay the applicable Copayment or Coinsurance for prescription drugs for the rest of the calendar year. Your cost share is subject to the Annual Out-of-Pocket Maximum.

   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.

   Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Coinsurance.

   Contraceptive drugs and devices:
   a. For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Summary Chart."

   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:
   a. Available in the United States only from a single manufacturer; and
   b. Not listed as generic in the then-current commercially available drug database(s) Health Plan subscribes to;

   are provided at the brand-name Copayment. 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; or
   b. Physician to whom a Member has been referred by a Plan Physician; or
   c. Dentist (when prescribed for acute conditions); and

   are 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 a Member requests a brand-name drug when a generic equivalent drug is the preferred product, the Member must pay the brand-name Copayment, 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, the Member pays only the brand-name Copayment.

b. Insulin.

2. Limitations:
   a. Some drugs may require prior authorization.
   b. Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.
   c. Plan Physicians may apply for formulary exceptions in cases where it is Medically Necessary.

3. Drugs, Supplies and Supplements Exclusions:
   a. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   b. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   c. Drugs and injections for the treatment of sexual dysfunction.
   d. Drugs or injections for treatment of involuntary infertility.
   e. Drugs to shorten the length of the common cold.
   f. Drugs to enhance athletic performance.
   g. Drugs available over the counter and by prescription for the same strength.
   h. Drugs for the treatment of weight control.
   i. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   j. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   k. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.

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

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STATE OF COLORADO

Important plan information

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