DIRECTORY

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

1. Schedule of Benefits (Who Pays What)

See ***"Summary Chart"*** and/or ***"Benefits"***

2. Title Page (Cover Page)

No corresponding section name

3. Contact Us

See ***"Contact Us"***

4. Table of Contents

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

5. Eligibility

See ***"Eligibility and Enrollment"***

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

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

7. Benefits/Coverage (What is Covered)

See ***"Benefits"***

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

See ***"Eligibility and Enrollment," "Exclusions, Limitations and Reductions"*** and ***"Additional Provisions"***

9. Member Payment Responsibility

See ***"Introduction," Miscellaneous Provisions," "Summary Chart"*** and/or ***"Benefits"***

10. Claims Procedure (How to File a Claim)

See ***"Internal Claims and Appeals Procedure and External Review," "Member Satisfaction Procedure"*** and/or ***"Additional Provisions"***

11. General Policy Provisions

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

12. Terminations/Nonrenewal/Continuation

See ***"Introduction," "Termination of Membership"*** and ***"Rescission of Membership"***

13. Appeals and Complaints

See ***"Internal Claims and Appeals Procedure and External Review," "Member Satisfaction Procedure"*** and/or ***"Additional Provisions"***

14. Information on Policy and Rate Changes

See ***"Introduction"***

15. Definitions

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

CONTACT US

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

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

Clinical Contact Center (to schedule an appointment)

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

Behavioral Health

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

Member Services – Available Monday through Friday, 8 a.m. to 6 p.m., except major holidays

CALL	Toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**kp.org**

Utilization Management

CALL	**1-800-632-9700 (**Member Services**)**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing and speaking.
FAX	**1-866-529-0934**
WRITE	**Utilization Management** **Kaiser Foundation Health Plan of Colorado** **Waterpark I** **2500 South Havana Street** **Aurora, CO 80014-1622**

Patient Financial Services

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

Member Relations (to file an appeal)

CALL	Toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Member Relations** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

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

Membership Administration

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

Transplant Administrative Offices

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

TABLE OF CONTENTS

I. INTRODUCTION 1

A. About This Individuals and Families Membership Agreement 1

B. Premiums 1

II. ELIGIBILITY AND ENROLLMENT 1

A. Who Is Eligible 1

1. General 1
2. Subscribers 1
3. Dependents 1

B. Adding Dependents 2

1. Newborn and Newly Adopted Children 2
2. Other Dependents 2

C. Members with Medicare 2

D. Persons Not Eligible to Enroll 2

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

III. HOW TO OBTAIN SERVICES 3

A. Your Primary Care Provider 3

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

B. Access to Other Providers 3

1. Referrals and Authorizations 3
2. Specialty Referrals 3
3. Second Opinions 4

C. Plan Facilities 4

D. Getting the Care You Need 4

E. Visiting Other Kaiser Regional Health Plan Service Areas 4

F. Out-of-Area Benefit 4

G. Using Your Health Plan Identification Card 5

IV. BENEFITS 5

Copayments and Coinsurance 6

Annual Out-of-Pocket Maximums 6

A. Outpatient Care 7

Outpatient Care for Preventive Care, Diagnosis and Treatment 7

B. Hospital Inpatient Care 7

1. Inpatient Services in a Plan Hospital 7
2. Hospital Inpatient Care Exclusions 7

C. Ambulance Services and Other Transportation 7

1. Coverage 7
2. Ambulance Services Exclusions 8

D. Dialysis Care 8

E. Drugs, Supplies, and Supplements 8

1. Coverage 8
2. Limitations 9
3. Drugs, Supplies, and Supplements Exclusions 10

F. Durable Medical Equipment (DME) and Prosthetics and Orthotics 10

1. Durable Medical Equipment (DME) 10
2. Prosthetic Devices 11
3. Orthotic Devices 11

G. Early Childhood Intervention Services 12

1. Coverage 12
2. Limitations 12
3. Early Childhood Intervention Services Exclusions 12

H. Emergency Services and Urgent Care 12

1. Emergency Services ... 12
2. Urgent Care ... 14

I. Family Planning Services ... 14
1. Coverage ... 14
2. Family Planning Services Exclusions ... 15

J. Gender Affirming Health Services ... 15
1. Coverage ... 15
2. Gender Affirming Health Services Exclusions ... 15

K. Health Education Services ... 15

L. Hearing Services ... 16
1. Persons Under the Age of 18 Years ... 16
2. Persons Age 18 Years and Over ... 16

M. Home Health Care ... 16
1. Coverage ... 16
2. Home Health Care Exclusions ... 16
3. Special Services Program ... 16

N. Hospice Care ... 16

O. Infertility Services ... 17
1. Coverage ... 17
2. Limitations ... 17
3. Infertility Services Exclusions ... 17

P. Mental Health Services ... 177
1. Coverage ... 177
2. Mental Health Services Exclusions ... 18

Q. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services ... 18
1. Coverage ... 18
2. Limitations ... 18
3. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services Exclusions ... 18

R. Preventive Care Services ... 19

S. Reconstructive Surgery ... 19
1. Coverage ... 19
2. Reconstructive Surgery Exclusions ... 19

T. Skilled Nursing Facility Care ... 19
1. Coverage ... 19
2. Skilled Nursing Facility Care Exclusion ... 19

U. Substance Use Disorder Services ... 19
1. Inpatient Medical and Hospital Services ... 19
2. Residential Rehabilitation ... 20
3. Outpatient Services ... 20
4. Substance Use Disorder Services Exclusion ... 20

V. Transplant Services ... 20
1. Coverage ... 20
2. Related Prescription Drugs ... 20
3. Terms and Conditions ... 20
4. Transplant Services Exclusions and Limitations ... 21

W. Vision Services ... 21
1. Coverage ... 21
2. Vision Services Exclusions ... 21

X. X-ray, Laboratory, and Advanced Imaging Procedures ... 21
1. Coverage ... 21
2. X-ray, Laboratory, and Advanced Imaging Procedures Exclusions ... 21

V. EXCLUSIONS, LIMITATIONS AND REDUCTIONS ... 22

A. Exclusions ... 22

B. Limitations ... 24

C. Reductions ... 24

1. Injuries or Illnesses Alleged to be Caused by Other Parties 24
2. Traditional or Gestational Surrogacy 25

VI. INTERNAL CLAIMS AND APPEALS PROCEDURE AND EXTERNAL REVIEW 26
VII. MEMBER SATISFACTION PROCEDURE 35
VIII. TERMINATION OF MEMBERSHIP 35
A. How We May Terminate Your Membership 35
B. How You May Terminate Your Membership 36
C. Notice, Refunds and Payments 36
D. Right to Benefits Ends 36
E. Termination Due to Loss of Eligibility 36
F. Moving Outside of our Service Area 36
G. Moving to Another Kaiser Regional Health Plan Service Area 36
IX. RESCISSION OF MEMBERSHIP 36
X. MISCELLANEOUS PROVISIONS 36
A. Administration of Agreement 36
B. Advance Directives 36
C. Agreement Binding on Members 37
D. Amendment of Agreement 37
E. Applications and Statements 37
F. Assignment 37
G. Attorney Fees and Expenses 37
H. Charge for Checks With Insufficient Funds 37
I. Claims Review Authority 37
J. Contracts with Plan Providers 37
K. Genetic Testing Information 37
L. Governing Law 37
M. No Waiver 38
N. Nondiscrimination 38
O. Notices 38
P. Overpayment Recovery 38
Q. Privacy Practices 38
XI. DEFINITIONS 38
XII. APPENDIX 41
A. Access Plan 41
B. Access to Services for Foreign Language Speakers 41
C. Value-Added Services 41
D. Women's Health and Cancer Rights Act 42
ADDITIONAL PROVISIONS 43

I. INTRODUCTION

A. About This Individuals and Families Membership Agreement

This Individual Membership Agreement (Membership Agreement), all applications for coverage and any changes to such applications, and any amendments to this Membership Agreement, are legally binding and constitute the entire contract between you, as the Subscriber, and Kaiser Foundation Health Plan of Colorado ("Health Plan"). If you are the person who applied for Health Plan membership and agree to be responsible for payment, you are the "Subscriber." You and your enrolled Dependents are "Members." Health Plan is sometimes called "Plan," "we," or "us" in this Membership Agreement. Out-of-Health Plan is sometimes referred to as "out-of-Plan."

By paying monthly Premiums, you accept this Membership Agreement for yourself and all your enrolled Dependents. Your membership continues from month to month. Members and applicants for membership must complete any applications, forms, or statements that we reasonably request. In addition, we may adopt reasonable rules and interpretations to administer this Membership Agreement effectively.

We may modify this Membership Agreement in the future. If we do, we will notify you in writing at least 90 days before your Health Plan benefit changes are effective. If you continue to pay monthly Premiums or accept benefits after your health care benefit change has gone into effect, you thereby agree to the change. Your consent also covers your enrolled Dependents.

You have a 10-day period in which to examine and return this Membership Agreement and have your initial Premiums refunded. If you receive Services during this 10-day period, and you return the Membership Agreement to receive a refund, you will be billed as a non-Member for any Services received during this 10-day period.

You or we may end your Health Plan membership as described under the "Termination of Membership" and "Rescission of Membership" sections in this booklet.

This Membership Agreement describes your benefits for 2025.

Health Plan believes this coverage is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services.

B. Premiums

Premiums must be paid in advance. You must then pay the correct amount before the beginning of a month to have coverage for that month. If you do not pay in time, we will send you a notice that you are in default. You then have a grace period in which to pay your Premiums without loss of membership. If you do not pay within this time, we will terminate your membership. Only Members for whom we have received the correct amount are entitled to benefits under this Membership Agreement.

We will provide a 31-day grace period for payment of any Premiums other than the first month's Premiums. We will send written notice stating when the grace period begins. If we do not receive your Premiums by the end of the grace period, we may terminate your membership so that it ends at 11:59 pm on the last day of the grace period, and we or providers may bill you as a non-Member for any Services you received after your last day of membership.

II. ELIGIBILITY AND ENROLLMENT

A. Who Is Eligible

1. General

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

   a. You must meet the Subscriber or Dependent eligibility requirements as described below; and
   b. You must live or reside within our Service Area when you apply to enroll. Our Service Area is described in the "Definitions" section; and
   c. You cannot live or reside in another Kaiser regional health plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.**

2. Subscribers

   To be eligible to enroll as a Subscriber, you must meet our current requirements for **Kaiser Permanente for Individuals and Families** membership.

3. Dependents

   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents, as described in the "Adding Dependents" section:

   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 age 26.
c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under age 26; 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 age 26 and over 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.

The Dependent limiting age is the end of the year in which age 26 is reached. If they continue to meet all other eligibility requirements, a Dependent child will continue to be eligible until the Dependent child reaches this age.

A grandchild of you or your Spouse cannot be enrolled as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed permanent legal guardian of the grandchild. This includes an adopted or foster grandchild.

B. Adding Dependents

1. Newborn and Newly Adopted Children

   You may add a newborn child or a newly adopted child as your Dependent. To enroll the child, please call **Member Services.** Children who are not enrolled within 31 days after becoming your Dependent may be required to meet any current requirements for individual membership.

   a. Newborn Children

      The membership effective date for newborn children is the moment of birth. A newborn child is covered for the first 31 days following birth. In order to be covered, Services must be provided or arranged by a Plan Provider except for Emergency Services.

      i. If the addition of the newborn child to your coverage will change the amount you are required to pay for that coverage, then in order for the newborn to continue coverage beyond the first 31-day period of coverage, you are 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 newborn's birth.
      ii. If the addition of the newborn child to your coverage will not change the amount you pay for coverage, you must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto your Health Plan coverage.

   b. Newly Adopted Children

      The membership effective date for newly adopted children (including children newly placed for adoption), is the date of the adoption or placement for adoption. You must enroll the child within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

      i. If the addition of the newly adopted child to your coverage will change the amount you are required to pay for that coverage, then in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, you are 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 your coverage will not change the amount you pay for coverage, you must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto your Health Plan coverage.

2. Other Dependents

   All other eligible Dependents (such as a new Spouse) must meet our current requirements for individual membership. To enroll other Dependents, please call **Member Services.**

C. Members with Medicare

This plan is not intended for persons who are eligible for or entitled to coverage under Medicare (such as Parts A and/or B). If you are or become eligible for Medicare during the term of this Membership Agreement you should contact **Member Services** immediately to see if you are eligible to enroll in a Kaiser Permanente Senior Advantage plan.

D. Persons Not Eligible to Enroll

A person may not enroll if we previously terminated their Health Plan membership for a reason stated under "Termination of Membership" or "Rescission of Membership."

E. 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.

III. HOW TO OBTAIN SERVICES

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

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)," in "Emergency Services and Urgent Care" in the "Benefits" section.
- "Urgent Care" in "Emergency Services and Urgent Care" in the "Benefits" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Out-of-Area Benefit" in this section.

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

A. Your Primary Care Provider

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

1. Choosing Your Primary Care Provider

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

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

2. Changing Your Primary Care Provider

   Please call the **Clinical Contact Center** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

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

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

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

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

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

2. Specialty Referrals

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

Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

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

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

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

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

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

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

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities.**

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

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency department or Independent Freestanding Emergency Department.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to the "Emergency Services" section of this Membership Agreement.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. There may be instances when you need to receive unauthorized urgent care outside our Service Area. The Copayment for Urgent Care listed in the "Benefits" section will apply. For additional information about urgent care, please refer to the "Urgent Care" section of this Membership Agreement.

E. Visiting Other Kaiser Regional Health Plan Service Areas

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

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

F. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser Foundation Health Plan service area.

The Out-of-Area Benefit is limited to covered Services, including prescription drugs that are covered under this Membership Agreement:

1. Office visit exam charge limited to:
   a. Primary care visit.

b. Specialty care visit.
c. Preventive care visit.
d. Gynecology care visit.
e. Mental health visit.
f. Substance use disorder visit.
g. Visits with the administration of allergy injections.

2. Diagnostic X-rays.
3. Prescription drug fills.

We will pay 80% of Charges for covered Services, and you are responsible for paying the remaining 20% of Charges. The benefit is limited to $1,200 per Accumulation Period.

Exclusions and Limitations

The Out-of-Area Benefit does not include the following Services:

1. Other Services provided during a covered office visit such as, but **not limited** to: laboratory tests, procedures, and office administered drugs and devices except for allergy injections.
2. Services received outside the United States.
3. Transplant Services.
4. Services covered outside the Service Area under another section of this Membership Agreement (e.g. "Emergency Services and Urgent Care").
5. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, pediatric dental, hearing exams, home health visits, hospice services, immunizations, physical, occupational, and speech therapy, and applied behavioral analysis (ABA).
6. Breast cancer screening and/or imaging.
7. Ultrasounds.
8. Advanced imaging procedures, including but not limited to CT, PET, MRI, nuclear medicine.
9. Any and all Services not listed in the Coverage section of this benefit.

G. Using Your Health Plan Identification Card

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

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

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

IV. BENEFITS

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

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this Membership Agreement: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this Membership Agreement: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) Emergency Services, Urgent Care, certain Post Stabilization Care Services that qualify as Emergency Services (under applicable federal law and state law), and Ancillary Services for which you have prior Authorization in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and
- Your provider has received prior Authorization for your Services, as appropriate. When you receive covered Services for which you do not have Prior Authorization or that you receive from Out-of-Plan Providers or from Out-of-Plan Facilities that have not been approved by us in advance, we will not pay for them except when they are Emergency Services or urgent care.

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

Copayments and/or Coinsurance may apply to the benefits listed below. Please refer to the "Copayments and Coinsurance" section and individual benefit sections. You will also be required to pay any amount in excess of eligible Charges and any amount for Services provided by an Out-of-Plan Provider when you consent to their provision of Services.

Copayments and Coinsurance

- Copayments and/or Coinsurance listed in this Membership Agreement apply to covered Services provided to Members enrolled in this plan.
- Copayments and/or Coinsurance are due at the time you receive the Service.
- You may be responsible for any amounts over eligible Charges in addition to any Copayment and/or Coinsurance.
- You may be charged separate Copayments and/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 receive a bill for any Copayments and/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.
- You, as the Subscriber, are responsible for any Copayments and/or Coinsurance, incurred by your Dependents enrolled in the plan.
- For items ordered in advance, you pay the Copayment and/or Coinsurance in effect on the order date.

Annual Out-of-Pocket Maximums

Out-of-Pocket Maximums: There are limits to the total amount of Copayments or Coinsurance you must pay during the Accumulation Period for the covered Services listed below. Those limits are: $3,000 per individual or $7,500 per family. Copayments or Coinsurance for a benefit or Service that is not covered under your plan will not apply toward the limits.

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

Individual Subscriber: Member is responsible for meeting the individual Out-of-Pocket Maximum.

Family Unit: Each Member is responsible for meeting their individual Out-of-Pocket Maximum until the family Out-of-Pocket Maximum is met. The individual Out-of-Pocket Maximums are combined to satisfy the family Out-of-Pocket Maximum. Once the family Out-of-Pocket Maximum is met, all individual Out-of-Pocket Maximum requirements do not apply for the remainder of the Accumulation Period.

After reaching the Out-of-Pocket Maximum limits, Members continue to pay the applicable Copayment or Coinsurance for covered Services that do not apply to the limits.

1. Copayments or Coinsurance for the following covered Services apply toward these limits:
   a. **Coinsurance** for the following Services:
      - Ambulance.
      - Outpatient substance use disorder.
      - Outpatient mental health.
      - Hormonal treatment of prostate cancer.
   b. Copayments or Coinsurance for the following Services:
      - Inpatient hospice.
      - Inpatient hospital (excludes all inpatient mental health).
      - Inpatient substance use disorder.
      - Outpatient surgery.
2. The following Services do not apply to the Out-of-Pocket Maximum:
   a. **Copayments** for the following Services:
      - Ambulance.
      - Office visits.
      - Outpatient substance use disorder.
      - Outpatient mental health.
   b. Infertility Services.
   c. All other covered Services not listed in section 1 above.

If you have any questions, please call **Patient Financial Services**.

A. Outpatient Care

Outpatient Care for Preventive Care, Diagnosis and Treatment
$20 Copayment each visit

We cover, only as described under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this Membership Agreement, the following outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in a physician's office, during medical 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 (**$30 Copayment each visit**).
3. Consultation with clinical pharmacists.
4. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. Member may receive Services from a certified nurse midwife. See the applicable sections of "Benefits" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit (**No Charge**).
5. Outpatient surgery (**$150 Copayment each visit**). Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

   Note: Services provided during post-surgical office visits may have a cost share.
6. Blood, blood products and their administration.
7. House calls when care can best be provided in your home as determined by a Plan Provider.
8. Second opinion.
9. Medical social Services.
10. Preventive care Services. See "Preventive Care Services" in this "Benefits" section for more details.
11. Virtual care Services.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital
   $1,000 Copayment per admission

   We cover, only as described under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this Membership Agreement, the following inpatient Services in a Plan Hospital when the Services are generally and customarily provided by acute care general hospitals in our Service Area:
   a. Room and board, such as semiprivate accommodations, or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section**.** If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. All charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's 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. Blood, blood products and administration.
      iii. Prescribed drugs and medicines.
      iv. Diagnostic laboratory tests and X-rays.
      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 and Other Transportation

1. Coverage
   20% Coinsurance up to $500 per trip

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

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

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

D. Dialysis Care

$30 Copayment each visit

We cover dialysis Services related to acute renal failure and end-stage renal disease, upon payment of your office visit Copayment if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and
4. A Plan Provider provides a written referral for care at the facility.

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

E. Drugs, Supplies, and Supplements

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

For outpatient prescription drugs and/or items that are covered under the "Drugs, Supplies, and Supplements" section and obtained at a pharmacy owned and operated by Health Plan, you may be able to use approved manufacturer coupons as payment for the Copayment, Coinsurance, and/or Deductible that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire Copayment, Coinsurance, and/or Deductible for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information about the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

"Preferred" when used in this Membership Agreement, refers to drugs that are included in the Health Plan Drug Formulary. The term "non preferred" refers to drugs that are not included in the Health Plan Drug Formulary.

1. Coverage
   a. Outpatient Prescription Drugs
      The following drugs are covered only when prescribed by: (i) a Plan Provider, or (ii) a provider to whom a Member has been referred by a Plan Provider, or (iii) a dentist (when prescribed for acute conditions), and obtained at Plan Pharmacies:

      i. Insulin. You are not responsible for more than $100 per thirty-day supply of all covered prescription insulin drugs.
      ii. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on kp.org, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.
      iii. A five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a 12-month period.
      iv. Drugs for which a prescription is required by law. Prescribed covered drugs are provided at a maximum charge of: (A) **$15** for each preferred generic drug, or (B) **$30** for each preferred brand-name drug or medication not having a generic or a generic equivalent. If your prescription drug has a Copayment and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the applicable Copayment. The drug formulary, discussed above, also applies.

      Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay a **$30 Copayment**, plus any difference in price between the preferred generic equivalent drug prescribed or authorized by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and

authorized by the Plan due to Medical Necessity, you pay only the brand-name Copayment or Coinsurance.

The amount covered cannot exceed a 30-day supply for each maintenance drug or up to a 30-day supply for each non-maintenance drug. Certain drugs with a significant potential for waste and diversion will be provided for up to a 30-day supply, at the applicable prescription drug Copayment or Coinsurance. 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 prescribed amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance for a 30-day supply for maintenance drugs or up to a 30-day supply for non-maintenance drugs.

b. Administered Drugs

Some drugs may require prior Authorization. We cover the following administered drugs as part of your Hospital Inpatient Care and Skilled Nursing Facility benefit. If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered without Charge:

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

We cover injectable hormone therapy prescribed for the treatment of prostate cancer at a Coinsurance of 20%. If a Plan Provider determines that no clinically equivalent alternative therapy, such as surgery, exists, then these drugs are fully covered.

c. Contraceptive Drugs and Devices

We cover:

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

ii. a prescribed vaginal contraceptive ring intended to last for a three-month period.

d. Prescriptions by Mail

Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order. If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to a 90-day supply by mail order, at a charge of two (2) prescription drug Copayments or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

e. Food Supplements

Prescribed amino acid modified products, used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition and parenteral nutrition 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.

f. Diabetic Supplies and Accessories

Diabetic 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, home glucose monitoring supplies, glucose test strips, acetone test tablets, nitrate screening test strips for home use for pediatric patients and disposable syringes for the administration of insulin and are provided upon payment of a 20% Coinsurance for a 30-day supply per item when obtained at Plan Pharmacies or from sources designated by Health Plan.

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. If you experience a severe adverse reaction from a covered countermeasure, please visit hrsa.gov/cicp.
b. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
c. We may apply Step Therapy to certain drugs with some exceptions. The exceptions are:
   i. substance use disorder drugs;
   ii. stage four advanced metastatic cancer drugs;
   iii. FDA-approved HIV infection prevention drugs.

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

3. Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as: bandages; gauze; tape; antiseptics; dressings; and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction.
   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. Prescription drugs received from the pharmacy for infertility services.
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs and/or drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this Membership Agreement.
   o. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."

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

20% Coinsurance up to a $2,000 annual maximum benefit per Accumulation Period

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME for use in the home or during a covered stay in a Skilled Nursing Facility, including replacements other than those necessitated by misuse, theft, or loss, is provided upon payment of a 20% Coinsurance 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. After the maximum benefit per Accumulation Period is paid by Health Plan, any additional items of DME, prosthetics, orthotics and/or necessary repairs and adjustments will be based upon Charges set for non-Members.

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 Membership Agreement may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to: (1) A standard item of DME, orthotic device or prosthetic device that adequately meets your medical needs; and (2) an annual maximum benefit of $2,000 paid by Health Plan per Accumulation Period; and (3) for stays in a Skilled Nursing Facility, the DME or prosthetics and orthotics must be ordinarily furnished by the Skilled Nursing Facility.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, is Medically Necessary, and is not of use to a person in the absence of an injury or illness. 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, insulin pump supplies, and continuous glucose monitors are provided when clinical guidelines are met and when obtained from sources designated by Health Plan. The maximum benefit does not apply to insulin pumps.

iii. Oxygen and oxygen dispensing equipment used in your home (including an institution used as your home) is covered in the Service Area. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing order and obtain your oxygen from the vendor designated by Health Plan.
iv. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee, or you must pay Health Plan or its designee, the fair market price, established by Health Plan, for the equipment.

b. Durable Medical Equipment Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

c. Durable Medical Equipment Exclusions
i. Electric monitors of bodily functions, except infant apnea monitors are covered.
ii. Devices to perform medical testing of body fluids, excretions, or substances, except that nitrate urine test strips for home use for pediatric patients are covered.
iii. Disposable supplies for home use such as: bandages; gauze; tape; antiseptic; dressing; and ace-type bandages.
iv. More than one piece of DME serving essentially the same function, except for replacements.
v. Spare equipment or alternate use equipment.
vi. Replacement of lost or stolen equipment.
vii. Repair, adjustments, or replacements necessitated by misuse.
viii. Comfort, convenience, or luxury equipment or features.
ix. Exercise or hygiene equipment.
x. Non-medical items such as sauna baths or elevators.

2. Prosthetic Devices
a. Coverage
Prosthetic devices are those rigid or semi-rigid devices which are required to replace all or any 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, are covered without Charge. The maximum benefit does not apply to internally implanted devices.
ii. Prosthetic devices for Members who have had a mastectomy are covered. 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. The maximum benefit does not apply to prosthetic devices needed following a mastectomy.
iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan. The maximum benefit does not apply to prosthetic devices needed for the treatment of cleft lip and cleft palate.
iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg are covered when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this Membership Agreement. The maximum benefit does not apply to prosthetic arms and legs.
v. Additional prosthetic device or devices if the treating physician determines that the additional prosthetic device or devices are necessary to enable the covered person to engage in physical recreational activities.

You may have additional coverage for prosthetic devices. See "Additional Provisions."

b. Prosthetic Devices Exclusions
i. Dental prostheses, except for Medically Necessary prosthodontic treatment.
ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
iii. More than one prosthetic device for the same part of the body, with the exception of replacements, spare devices, or alternate use devices.
iv. Replacement of lost or stolen prosthetic devices.
v. Repair, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
a. Coverage
Orthotic devices are those rigid or semi-rigid devices which are required to support or correct a defective form or function or 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, orthotic devices for podiatric use and arch supports.
ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.

iii. Experimental and research braces.
iv. More than one orthotic device for the same part of the body, with the exception of replacements; spare devices or alternate use devices.
v. Replacement of lost or stolen orthotic devices.
vi. Repair, adjustments, or replacements necessitated by misuse.

G. 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 annual maximum benefit amount payable according to state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the maximum benefit amount payable according to state law is satisfied.

2. Limitations

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

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

H. Emergency Services and Urgent Care

Emergency Services: $100 Copayment each visit
Urgent Care: $50 Copayment each visit

1. Emergency Services

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

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Emergency Services are provided by a Plan Provider or an Out-of-Plan Provider. Even if you receive Emergency Services from a Plan Provider, you must still obtain prior Authorization from us before you receive Post Stabilization Care from such Plan Provider. We may direct that you receive covered Post Stabilization Care at a particular Plan Hospital or other Plan Facility (such as a Skilled Nursing Facility) so that we may better coordinate your care using Plan Providers and our electronic medical record system. We will pay for Post Stabilization Care only at the Plan Provider authorized by us. If you or your treating providers do not obtain prior Authorization from us for Post Stabilization Care Services that require prior Authorization, we will not pay any amount for those Services and you may be liable to pay for these Services, in addition to any amounts such as Deductibles, Copayments, or Coinsurance.

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 Membership Agreement. Coverage for Services that are not Emergency Services, Post Stabilization Care, or Urgent Care Services as described in this "Emergency Services and Urgent Care" section will be covered as described under other sections of this EOC. Please refer to the "Schedule of Benefits" for Copayment and Coinsurance information. If you are admitted to a hospital from its emergency department because your condition is not stabilized, the Copayment or Coinsurance shown under "Hospital Inpatient Care" in the "Schedule of Benefits" applies.

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

"Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan

Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency department of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

When you receive Emergency Services from Out-of-Plan Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law and state law. We will not require prior Authorization for such Post Stabilization Care at a non-Plan Hospital when your attending Out-of-Plan Provider determines that, after you receive Emergency (screening and stabilization) Services, you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account your medical condition.

Out-of-Plan Providers may provide notice and seek your consent to provide Post Stabilization Care Services or other covered Services. Such Services will not be covered when you do not obtain prior Authorization as described herein. If you (or your authorized representative) consent to the furnishing of Services by Out-of-Plan Providers, then you will be responsible for paying for such Services in the absence of any prior Authorization. In addition, if you (or your authorized representative) consent to the provision of Services by an Out-of-Plan Provider, then we will not pay for such Services, and the amount you pay will not count toward satisfaction of the Deductible, if any, or the Out-of-Pocket Maximum(s).

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

i. We cover out-of-Plan Emergency Services as follows:
   A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed.
   B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the Emergency Medical Condition.

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

   When you receive Emergency Services in Colorado (and federal law and state law do not require us to consider the Post Stabilization Care as Emergency Services), we cover Post Stabilization Care only if we provide prior Authorization for the Post Stabilization Care. **Therefore, it is very important that you, your provider including your Out-of-Plan Provider, or someone else acting on your behalf, call us to notify us that you need Post Stabilization Care and to get prior Authorization from us before you receive the Post Stabilization Care.**

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

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

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

c. Payment

Our payment is reduced by:

i. the Copayment and/or Coinsurance for Emergency Services. The emergency department Copayment, if applicable, is 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. any other payments you would have had to make if you received the same Services from our Plan Providers; and
iv. all amounts paid or payable, or which in the absence of this Membership Agreement would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third party liability.

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

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

Note: If you receive Emergency Services or Post Stabilization Care from an Out-of-Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance transportation described under the "Ambulance Services and Other Transportation" section, you may have to pay the Out-of-Plan Provider and file a claim for reimbursement unless the Out-of-Plan Provider must refrain from billing you under applicable law or agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by an Out-of-Plan Provider as part of your Emergency Services or Post Stabilization Care even if you receive the services at a Plan Provider.

2. Urgent Care

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

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. There may be instances when you need to receive urgent care outside our Service Area. When urgent care Services are required, we cover urgent care Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the urgent care Services would be covered under your plan if you had received them inside our Service Area. The Urgent Care Copayment listed in this "Benefits" section will apply. For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

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

Note: The procedure for receiving reimbursement for out-of-Plan urgent care Services is described in the "Internal Claims and Appeals Procedure and External Review" section regarding "Post-Service Claims and Appeals."

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

I. Family Planning Services

1. Coverage

Vasectomies: No Charge
Elective interruption of pregnancy (abortion): No Charge
Therapeutic interruption of pregnancy (abortion): No Charge

We cover family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control at your primary care visit Copayment. See "Outpatient Care."

We cover the following at your primary care visit Copayment, specialty care visit Copayment or outpatient surgery Copayment, depending on where the procedure is performed (See "Outpatient Care" for your applicable Copayment or Coinsurance):

a. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control.
b. Tubal ligations.
c. Vasectomies.
d. Interruption of pregnancy (abortion). Your group may exclude coverage for part or all interruption of pregnancy services. Please refer to the "Schedule of Benefits (Who Pays What)".

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

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

J. Gender Affirming Health Services

We cover gender affirming health Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet Utilization Management Program Criteria to be eligible for coverage.

1. Coverage

   Non-surgical Services:
   a. Office visits and mental health visits.
   b. Laboratory Services and X-ray Services.
   c. Hormone therapy visits and administration.
   d. Facial and body hair removal (assigned male at birth).
   e. Outpatient prescription drugs, if covered by your plan.
   f. Inpatient and outpatient hospital care.
   g. Treatment for complications of surgery.

   Surgical Services:
   a. Pre-surgical and post-surgical consultations with surgeon.
   b. Gender affirmation surgeries including:
      i. **Assigned female at birth**: hysterectomy; oophorectomy; metoidioplasty; phalloplasty; vaginectomy; scrotoplasty; erectile prosthesis; urethral extension; bilateral mastectomy with chest reconstruction; breast reduction; body contouring; gender affirming facial surgery.
      ii. **Assigned male at birth**: penectomy; vaginoplasty; clitoroplasty; labiaplasty; orchiectomy; breast augmentation; tracheal shave; body contouring; gender affirming facial surgery.
   c. Inpatient and outpatient hospital care.
   d. Treatment for complications of surgery.

   You pay the applicable Copayment, Coinsurance, and/or Deductible shown in the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Gender Affirming Health Services Exclusions
   a. Any gender affirming health Service that is not Medically Necessary.
   b. Calf implants.
   c. Hairline advancement.
   d. Pectoral implants.
   e. Permanent hair implantation
   f. Voice modification surgery.

K. Health Education Services

$20 Copayment each visit

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition. For each visit you will pay the applicable Copayment.

L. Hearing Services

$20 Copayment each visit

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 Over
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction.

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model.
      ii. Hearing aids and tests to determine their usefulness.

M. Home Health Care

No Charge

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

   Intermittent Care basis means skilled nursing, therapy, social work, and home health aide Services, that are not custodial, and require a skilled professional, and are provided less than 8 hours (combined) each day and 28 or fewer hours each week.

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

   Note: X-ray, laboratory, and advanced imaging procedures are not covered under this section. See "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Home Health Care Exclusions
   a. Custodial care. Custodial care is care that helps with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

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

No Charge

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

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

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

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

O. Infertility Services

50% Coinsurance

1. Coverage

We cover Services for diagnosis and treatment of involuntary infertility due to a medical condition and for Members who are unable to reproduce due to factors associated with their partner or lack of a partner. The following Services are covered: (a) Office visits, laboratory tests, X-rays; and (b) intrauterine insemination (IUI), except for donor sperm, donor eggs, donor embryos, and Services related to their procurement and storage. X-ray and laboratory procedures in conjunction with conception by artificial means are provided.

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

2. Limitations

a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
b. Services are covered only for the person who is the Member.

3. Infertility Services Exclusions

These exclusions apply to fertile as well as infertile individuals or couples.

a. Any and all Services to reverse voluntary, surgically induced, infertility.
b. Acupuncture for the treatment of infertility.
c. Donor sperm, eggs, or embryos.
d. All Services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intrafallopian transfer and zygote intrafallopian transfer are not covered.
e. Any and all Services, supplies, office administered drugs, and prescription drugs received from the pharmacy related to the procurement, transfer, and/or storage of donor semen, sperm, eggs, reproductive materials, and/or embryos, except as listed under Coverage.
f. Prescription drugs received from the pharmacy for infertility Services.
g. Any and all Services, supplies, office administered drugs, and prescription drugs received from the pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

P. Mental Health Services

1. Coverage

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

a. Inpatient Services

$1,000 Copayment per admission

We cover psychiatric hospitalization in a hospital or Residential Treatment Center designated by Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient:

room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

b. Outpatient Therapy
Individual visit: $20 Copayment each visit
Group visit: $10 Copayment each visit

We cover individual office visits and group office visits. Psychological testing as part of diagnostic evaluation is covered.

We cover partial hospitalization and intensive outpatient therapy.

We cover visits for the purpose of monitoring drug therapy.

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

We will not deny coverage for intentionally self-inflicted injuries, including attempted suicide.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Custodial Care, as defined in "Exclusions" under "Limitations/Exclusions (What is Not Covered)."

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

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility and Home Health Care
   $1,000 Copayment per admission

   We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit.

   b. Outpatient Care
   $20 Copayment each visit

   We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy). Coverage is provided for up to 20 visits per Accumulation Period for each type of outpatient therapy in a Plan Facility.

   c. Inpatient Rehabilitation Services
   We will cover treatment for up to 60 days per condition, per Accumulation Period, in an organized, inpatient rehabilitation Services program in a designated facility. We also cover inpatient rehabilitation Services without Charge while you are an inpatient in a designated facility.

   d. Pulmonary Rehabilitation
   $5 Copayment each visit

   Treatment in a pulmonary rehabilitation program is provided upon payment of a $5 Copayment each visit if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

   e. Therapies for Congenital Defects and Birth Abnormalities
   After the first 31 days of life, the limitations and exclusions applicable to this Membership Agreement 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 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity.

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

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

3. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services Exclusions
   a. Long-term rehabilitation.

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

No Charge

The preventive care Services that are covered under this plan are defined by Health Plan.

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.

Preventive Services may help you stay healthy. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services during a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services. For a complete list of covered Preventive Services under this Plan, please contact Member Services.

Note: In accordance with state law, you may receive an annual mental health wellness examination at your applicable preventive care Copayment or Coinsurance.

S. Reconstructive Surgery

See "Outpatient Care" and "Hospital Care" for your applicable Copayment or Coinsurance.

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

T. Skilled Nursing Facility Care

No Charge

1. Coverage
   We cover up to 100 days per Accumulation Period of skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical and biological supplies.
   d. Medical social Services.
   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 Health Plan.

   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 (DME) and Prosthetics and Orthotics"; X-ray, laboratory, and advanced imaging procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures."
2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Exclusions, Limitations and Reductions" section.

U. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   $1,000 Copayment per admission

   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
$1,000 Copayment per admission

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

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

3. Outpatient Services
Individual visit: $20 Copayment each visit
Group visit: $10 Copayment each visit

a. We cover individual office visits and group office visits.
b. We cover partial hospitalization and intensive outpatient therapy.
c. We cover visits for the purpose of monitoring drug therapy.

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

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

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

V. Transplant Services

1. Coverage for Members who are transplant recipients
Transplants are covered on a **LIMITED** basis as follows:
a. Covered transplants are limited: to kidney transplants; cornea transplants; heart transplants; heart-lung transplants; lung transplants; liver transplants liver transplants for children with biliary atresia and other rare congenital abnormalities; simultaneous kidney/pancreas transplants; pancreas alone transplants in accordance with this Membership Agreement, small bowel transplants, and small bowel and liver transplants, which are provided in accordance with this Membership Agreement.
b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.
c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.
d. Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant.
e. These Services must be directly related to a covered transplant for you.

Your applicable hospital Copayment, as listed in the "Benefits" section, will apply.

2. Coverage for Members who are living organ donors
We cover Services related to living organ donation for a Member who is a living organ donor. We will not impose any Deductibles, Copayments, Coinsurance, benefit maximums, waiting periods, or other limitations on coverage for the living organ donation.

3. Terms and Conditions
a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Health Plan. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.
b. Plan Providers must determine that you meet Utilization Management Program Criteria before you receive Services.
c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Health Plan. Medical Group's referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Health Plan selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.
d. After referral, if a Plan Provider or the medical staff of the referral facility determines you do 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 Membership Agreement) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Obtain Services" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

W. Vision Services

$20 Copayment each visit

1. Coverage

   We cover wellness exams and refraction tests 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 Provider or Plan Optometrist prescribes them for a specific medical condition.

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

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   e. Eyewear for protection, including but not limited to: industrial eyewear; safety eyewear; athletic safety eyewear; or eyewear required as a condition of employment.
   f. 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).
   g. Orthoptic (eye training) therapy or low vision therapy.

X. X-ray, Laboratory, and Advanced Imaging Procedures

1. Coverage
   a. Outpatient

      We cover the following Services:
      i. Diagnostic X-ray and laboratory tests, Services, and materials, which includes, but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds are covered without Charge.
         Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.
      ii. Therapeutic X-ray Services and materials (**$30 Copayment each visit**).
      iii. Advanced imaging procedures such as MRI, CT, PET, and nuclear medicine (**$100 Copayment each procedure**). **Note:** You will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association.

   b. Inpatient

      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes; electrocardiograms; electroencephalograms; MRI; CT; PET; and nuclear medicine are covered without Charge.

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

V. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this Membership Agreement. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section.

1. **Alternative Medical Services.** The following are not covered:
   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.
2. **Bariatric Surgery and Cosmetic Surgery Related to Bariatric Surgery.**
3. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.
4. **Certain Maternity Services that are not Medically Necessary.** Certain maternity Services that are not Medically Necessary, including but not limited to: home birth Services and doula Services.
5. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. Examples of this include cosmetic surgery related to bariatric surgery and hair prostheses due to hair loss. Exception: Services covered under "Reconstructive Surgery" in the "Benefits" section.
6. **Cryopreservation.** Any and all Services related to cryopreservation. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos.
7. **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. Activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.
8. **Dental Services.** Dental Services and dental X-rays, including dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma, or (c) Medically Necessary Services required for the direct treatment of a covered transplant procedure for a Member who is a transplant recipient. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.
9. **Directed Blood Donations.**
10. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
    a. Bandages.
    b. Gauze.
    c. Tape.
    d. Antiseptics.
    e. Dressings.
    f. Ace-type bandages.
    g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits" section.
11. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
    a. Items and services to increase academic knowledge or skills;
    b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
    c. Teaching and support services to increase academic performance;
    d. Academic coaching or tutoring for skills such as grammar, math, and time management;

e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of their license under Colorado law that is intended to address speech impediments;
f. Teaching you how to read, whether or not you have dyslexia;
g. Educational testing; testing for ability, aptitude, intelligence, or interest;
h. Teaching, or any other items or services associated with, recreational activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

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

13. **Excess Charges from Out-of-Plan Providers.** Charges from Out-of-Plan Providers that exceed eligible Charge(s).

14. **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. has not been recommended for coverage by the Interregional New Technology Committee, or the Medical Technology Assessment Team, or any committees reviewing new technologies within Kaiser Permanente, 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.

15. **Eye Surgery Services.** 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); orthoptic (eye training therapy).

16. **Genetic Testing and Gene Therapy.** Genetic testing and gene therapy, unless determined to be Medically Necessary and you meet Utilization Management Program Criteria.

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

18. **Residential Care.** Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Residential Treatment Center, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

19. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
20. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.
21. **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.
22. **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.
23. **Services that are the Subject of an Out-of-Plan Provider's Notice and Consent.** Amounts owed to Out-of-Plan Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable state or federal law.
24. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
25. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Obtain Services" section.
26. **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.
27. **Weight Management Facilities.** Services received in a weight management facility.
28. **Workers' Compensation or Employer's Liability.** If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services obtained at a Kaiser facility. We will not cover any workers compensation services obtained at contracted or non-contracted providers. Any workers' compensation services provided or paid for by the health plan are subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under applicable law.

    In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers applicable 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 Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

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

   If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under applicable law. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or

illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

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

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types.

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

The Phia Group, LLC.
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, reduce or, in any other manner, take action that may affect our rights under this provision without our prior, written consent.
If your estate, parent, guardian, or conservator asserts a claim against another party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights under applicable law to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

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

2. Surrogacy Arrangements: Traditional or Gestational Carriers
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which an individual agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

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

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

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

You must send this information to:

The Phia Group, LLC.
40 Pequot Way

Canton, MA 02021
Fax: 781-848-1154

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, reduce, or in any other manner, take action that may affect our rights under this "Surrogacy Arrangements" section without our prior, written consent.

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

If you have questions about your obligations under this provision, please call Member Services.

Note: A baby born under a Surrogacy Arrangement does not have health coverage rights under the surrogate's health coverage. The intended parents of a child born under a Surrogacy Arrangement will need to arrange for health coverage for the newborn.

VI. INTERNAL CLAIMS AND APPEALS PROCEDURE AND EXTERNAL REVIEW

You may file a claim (request for payment/reimbursement):

- by signing in to kp.org, completing an electronic form, and uploading supporting documentation;
- by mailing a paper form that can be obtained by visiting kp.org/formsandpubs or calling Member Services; or
- if you are unable to access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claims:
  1. Member/patient name and Medical Record Number
  2. The date you received the Services
  3. Where you received the Services
  4. Who provided the Services
  5. Why you think we should pay for the Services
  6. A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

Mailing address to submit your claim:

Kaiser Permanente
National Claims Administration - Colorado
P.O. Box 373150
Denver, CO 80237-3150

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

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

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

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

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

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

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Internal Claims and Appeal Procedures and External Review" section unless we fail to follow the claims and appeals process described in this Section VI.

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

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

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

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

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

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information.

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

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

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to **Member Relations**. To arrange to give testimony by telephone, you should contact **Member Services**.

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 for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

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

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

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

1. Pre-Service Claims and Appeals

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

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

   a. Pre-Service Claim

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

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

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

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

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

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

   b. Non-Urgent Pre-Service Appeal

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

      You have the right to request to appear at a review meeting. If you do not specify in your appeal that you would like to exercise your right to appear at a review meeting, we will perform a file review unless otherwise notified.

If you would like to appear in person or via telephone conference at the review meeting, please include this in your appeal request or contact Member Services by calling 1-800-632-9700, or 711 (TTY).

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

If you opt to have your appeal reviewed at a review meeting, within 60 calendar days following receipt of your request, we will hold a review meeting. Your review meeting will be before a review panel of health care professionals who have the appropriate expertise, who were not previously involved in the appeal, who do not have a direct financial interest in the outcome of the review and are not a subordinate of any person previously involved in the appeal.

We will notify you in writing at least 20 calendar days in advance of the review meeting date, and we will notify you about the date and time of this review meeting. If you feel you need more time to gather evidence to present to the review panel, we cannot unreasonably deny your request for postponement of the review meeting even if the postponement causes the review meeting to occur beyond the 60-calendar day requirement.

Regardless of whether you choose a file review or review meeting, the members of the appeals committee who review your appeal will consider any additional material provided by you. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5- calendar days prior to the meeting, unless any new material is developed after that 5-calendar day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

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 to **Member Services**, by mail or by fax to **Member Relations**.

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

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

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

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

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

2. Concurrent Care Claims and Appeals.

Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments, when the course of treatment or Services already

being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

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

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

a. Concurrent Care Claim

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

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

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

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

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

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

b. Non-Urgent Concurrent Care Appeal

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

You have the right to request to appear at a review meeting. If you do not specify in your appeal that you would like to exercise your right to appear at a review meeting, we will perform a file review unless otherwise notified.

If you would like to appear in person or via telephone conference at the review meeting, please include this in your appeal request or contact Member Services by calling 1-800-632-9700, or 711 (TTY).

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

If you opt to have your appeal reviewed at a review meeting, within 60 calendar days following receipt of your request, we will hold a review meeting. Your review meeting will be before a review panel of health care professionals who have the appropriate expertise, who were not previously involved in the appeal, who do not have a direct financial interest in the outcome of the review and are not a subordinate of any person previously involved in the appeal.

We will notify you in writing at least 20 calendar days in advance of the review meeting date, and we will notify you about the date and time of this review meeting. If you feel you need more time to gather evidence to present to the review panel, we cannot unreasonably deny your request for postponement of the review meeting even if the postponement causes the review meeting to occur beyond the 60-calendar day requirement.

Regardless of whether you choose a file review or review meeting, the members of the appeals committee who review your appeal will consider any additional material provided by you. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5- calendar days prior to the meeting, unless any new material is developed after that 5-calendar day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

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 to **Member Services**, by mail or by fax to **Member Relations**.

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

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

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

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

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

3. Post-Service Claims and Appeals

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

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

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

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

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

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

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

You have the right to request to appear at a review meeting. If you do not specify in your appeal that you would like to exercise your right to appear at a review meeting, we will perform a file review unless otherwise notified.

If you would like to appear in person or via telephone conference at the review meeting, please include this in your appeal request or contact Member Services by calling 1-800-632-9700, or 711 (TTY).

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

If you opt to have your appeal reviewed at a review meeting, within 60 calendar days following receipt of your request, we will hold a review meeting. Your review meeting will be before a review panel of health care professionals who have the appropriate expertise, who were not previously involved in the appeal, who do not have a direct financial interest in the outcome of the review and are not a subordinate of any person previously involved in the appeal.

We will notify you in writing at least 20 calendar days in advance of the review meeting date, and we will notify you about the date and time of this review meeting. If you feel you need more time to gather evidence to present to the review panel, we cannot unreasonably deny your request for postponement of the review meeting even if the postponement causes the review meeting to occur beyond the 60-calendar day requirement.

Regardless of whether you choose a file review or review meeting, the members of the appeals committee who review your appeal will consider any additional material provided by you. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5- calendar days prior to the meeting, unless any new material is developed after that 5-calendar day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

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

Appeals of Retroactive Membership Termination (Rescission or cancellation retroactively)

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

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

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

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

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

Appeals of Denial of Individual Plan Application

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

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

Membership Administration
P.O. Box 203004
Denver, CO 80220-9004

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

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

External Review

Following receipt of an adverse benefit determination 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 regarding a denial of a claim, in whole or in part, that (1) is 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; (3) a denial of a request for Services on the ground that the Service is experimental or investigational; (4) concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits; or, (5) involves consideration of whether we are complying with federal law and state law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130). If our final adverse decision does not involve an adverse benefit determination as described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

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

To request external review, you must:

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

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

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking.

You may request expedited external review simultaneously with your expedited internal appeal as permitted under this Membership Agreement. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

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

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

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

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

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure. 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 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.

VII. MEMBER SATISFACTION PROCEDURE

A. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by following the procedures listed:
   1. Sending your written complaint to **Member Relations**; or
   2. Telephoning **Member Services**.

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

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

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

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

VIII. TERMINATION OF MEMBERSHIP

A. How We May Terminate Your Membership

If you are inpatient in a hospital or institution, your coverage will continue until the date of discharge if your Membership Agreement terminates for reasons other than: nonpayment of Premiums; fraud; or abuse.

We may terminate your membership by giving you 30 days written notice including the reason for termination if you or any of your Dependents do one or more of the following:

1. Knowingly: (a) furnish incorrect or incomplete material information; or (b) fail to inform us of a material change in family status.
2. Knowingly: (a) misrepresent enrollment eligibility information or membership status; or (b) present an invalid prescription; or (c) misuse or permit the misuse of an ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Heath Plan or a Plan Provider.
3. Fail to make payments in full within the applicable grace period provided in the "Premiums" section (Section I. B.). Health Plan will notify you of nonpayment of Premiums within the applicable grace period and provide 30 days' advance notice of termination.

Termination of membership for any one of these reasons applies to all in your Family Unit. All rights to benefits cease on the termination date. 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 by calling **Member Services**; or by calling the Colorado Division of Insurance.

Except for fraud, we will not terminate membership based upon misstatements made by you commencing two (2) years after the effective date of this Membership Agreement.

We may report any Member fraud to the authorities for prosecution and pursue appropriate civil remedies.

We may also terminate your membership if we cease offering: (a) this particular product; or (b) this entire class of **Kaiser Permanente Individuals and Families** Membership Agreements.

B. How You May Terminate Your Membership

You may terminate membership for yourself or any Dependent effective at the end of any month by giving us at least 30 days' written notice at the following address: **Kaiser Permanente, Membership Administration, P.O. Box 203004, Denver, CO 80220-9004**.

C. Notice, Refunds and Payments

You will receive 30 days prior written notice if we terminate your membership. The notice will include: an explanation of why; and when your membership will end. If you have paid monthly Premiums beyond the termination date, you may be eligible for a refund. Any amount due to you for claims for while you were a Member will be paid to you. Any amounts you owe us will be deducted from any payment we make to you. We will make any payment due to you within 30 days of your termination.

D. Right to Benefits Ends

Your right to receive benefits ends when your membership ends, except as provided by state law.

E. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in Section II, we will provide 30 days' advance notice of termination that will include the reason for termination.

F. Moving Outside of our Service Area

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

G. Moving to Another Kaiser Regional Health Plan Service Area

If you move to another Kaiser regional health plan service area, you will be terminated from this plan, but you may be eligible for membership in the new service area. However, eligibility requirements, benefits, Premiums, Copayments and/or Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area. For information about applying for enrollment in another service area, please contact **Member Services** in that service area.

IX. RESCISSION OF MEMBERSHIP

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

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

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

X. MISCELLANEOUS PROVISIONS

A. Administration of Agreement

We may adopt reasonable policies, procedures, rules and interpretations that govern this Membership Agreement.

B. Advance Directives

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

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

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

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

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

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

C. Agreement Binding on Members

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

D. Amendment of Agreement

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

E. Applications and Statements

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

F. 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 any other rights, interests, or obligations under this Membership Agreement without our prior written consent.

G. Attorney Fees and Expenses

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

H. Charge for Checks With Insufficient Funds

You may be assessed a charge for any check written to Health Plan that is returned due to insufficient funds in your bank account.

I. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this Membership Agreement. We have the authority to review and evaluate claims that arise under this Membership Agreement. We conduct this evaluation independently by interpreting the provisions of this Membership Agreement.

J. Contracts with Plan Providers

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

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

For Emergency Services (including Post Stabilization Care that federal law and state law define as Emergency Services) provided by an Out-of-Plan Provider, your Deductible, Copayment and/or Coinsurance, as applicable, will be the same amount or percentage, as applicable, as they would be for Emergency Services provided by a Plan Provider pursuant to applicable state law or, if state law is inapplicable, then federal law. In addition, in the event that an Out-of-Plan Provider provides Ancillary Services at a Plan Provider, then your Deductible, Copayment and/or Coinsurance shall be calculated as required by applicable state law or, if state law is inapplicable, then federal law. In addition, if you (or your authorized representative) consent to the provision of Services by an Out-of-Plan Provider, then we will not pay for such Services, and the amount you pay will not count toward satisfaction of the Deductible, if any, or the Out-of-Pocket Maximum(s).

We may seek payment for any claims paid to Plan Providers for Services rendered after termination of your enrollment.

K. Genetic Testing Information

In accordance with state law: (1) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested. (2) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of group disability insurance or long-term care insurance coverage.

L. Governing Law

Except as preempted by federal law, this Membership Agreement will be governed in accordance with Colorado law. It may be modified from time to time by us as those laws may require. Any provision that is required to be in this Membership Agreement by state or federal law shall bind Members and Health Plan whether or not set forth in this Membership Agreement.

M. No Waiver

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

N. Nondiscrimination

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

O. Notices

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

P. Overpayment Recovery

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

Q. Privacy Practices

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

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Kaiser Permanente Medical Office Building or on our website, kp.org**.**

XI. DEFINITIONS

The following are terms used in this booklet and other materials connected with your coverage. When a defined term is used, it will have the meaning set forth in this section and it will be capitalized in the text. Any capitalized words not defined in this section that have precise meanings will be defined where they are used in the text.

Accumulation Period: As stated in the "Benefits" section, the period of time during which benefits are paid and are counted towards the maximum allowed for the specific benefit.

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

Ancillary Services: Services that are:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Plan Provider satisfies the notice and consent requirements under federal law and state law.

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

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

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

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the Charges in Health Plan's schedule of Medical Group and Health Plan Charges for Services provided to Members; or

2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the Charges in the schedule of Charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For Emergency Services received from Out-of-Plan Providers (including Post Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process; or
5. For all other Services received from Out-of-Plan Providers (including Post Stabilization Services that are not Emergency Services under federal law and Ancillary Services), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the event that neither state nor federal law prohibiting balance billing apply, then the amount agreed to by the Out-of-Plan Provider and us, or absent such an agreement, the usual, customary and reasonable rate for those services determined by us based on objective criteria.
6. 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 "Benefits" section.

Copayment (Copay): The specific dollar amount you must pay for a covered Service as listed in the "Benefits" section.

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period.

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

Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of a person or, with respect to a pregnant individual, the health of the individual or their unborn child;
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:
- An appropriate medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Post Stabilization Care furnished by an Out-of-Plan Provider (including a nonparticipating emergency facility) is covered as Emergency Services when federal law and state law applies AND
    - Your attending Out-of-Plan Provider determines that you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider within a reasonable travel distance, taking into account your medical condition; or,
    - You (or your authorized representative) are not in a condition to receive, and/or to provide consent to, the Out-of-Plan Provider's notice and consent form, in accordance with applicable state law pertaining to informed consent as determined by your attending Out-of-Plan Provider using appropriate medical judgment.

Note: Once your condition is stabilized, covered Services that you receive are Post Stabilization Care and not Emergency Services EXCEPT when you receive Emergency Services from Out-of-Plan Providers AND federal law and state law require coverage of your Post Stabilization Care as Emergency Services. Post Stabilization Care is subject to all of the terms and conditions of this EOC including but not limited to prior Authorization requirements unless federal law and state law applies and defines such Post Stabilization Care as Emergency Services.

Family Unit: A Subscriber and all of their Dependents.

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

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services. **Kaiser Permanente:** The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

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

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

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

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

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

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

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

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

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total cost share amount you must pay in an Accumulation Period for covered Services.

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this Membership Agreement. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

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

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Post Stabilization Care: Means Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. We cover Post Stabilization Care only when (1) it is considered to be Emergency Services under federal law and state law (without prior Authorization) or, (2) we determine that such Services are Medically Necessary pursuant to a request for prior Authorization for the Service.

Premiums: Periodic membership charges.

Residential Treatment Center: A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. The term Residential Treatment Center does not include a provider, or that part of a provider, used mainly for:

1. Nursing care.
2. Rest care.
3. Convalescent care.
4. Care of the aged.
5. Custodial Care.
6. Educational care.

Service Area: Our Service Area consists of certain geographic areas in Colorado which we designate by county. Our Service Area may change. Contact Member Services for a complete listing of our Service Area counties.

Services: Health care services or items.

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

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

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

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

Subscriber: A Member who is eligible for membership on their 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.

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

XII. APPENDIX

A. Access Plan

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

B. Access to Services for Foreign Language Speakers

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

C. Value-Added Services

In addition to the Services we cover under this Membership Agreement, 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 may need to:

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

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

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

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

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company

offering such service. Although Health Plan has no obligation to assist with this resolution, you may call Member Services, and a representative may try to assist in getting the issue resolved.

D. Women's Health and Cancer Rights Act

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

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

ADDITIONAL PROVISIONS

If you were enrolled in this plan on March 23, 2010, then the following statements are applicable to this Membership Agreement:

Grandfathered Health Plan

Health Plan believes this coverage is a ‘‘grandfathered health plan’’ under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call **Member Services**.

Preventive Services

The preventive care Services that are covered under this plan are defined by Health Plan. Please contact Member Services for a complete list of covered Preventive Services under this Plan.