TITLE PAGE (Cover Page)

Important Benefit Information Enclosed

Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

The health care coverage described in this EOC has been designed to be a High Deductible Health Plan (HDHP) compatible for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified High Deductible Health Plan.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

This EOC is for your Group's 2024 contract year.

NOTICE:

This policy provides **pediatric** dental coverage as required by the Affordable Care Act. For Members age nineteen (19) years and over, this policy provides limited dental services only.

kp.org

KAISER PERMANENTE®

[Used for 3-Tier POS

AMENDMENT TO EVIDENCE OF COVERAGE

SMALL GROUP POINT-OF-SERVICE (POS) PLAN

Your "3-Tier POS Plan" coverage gives you access to two different health care options each time you seek care. You can receive Services through Kaiser Foundation Health Plan (Health Plan) or through your separate coverage provided by the Kaiser Permanente Insurance Company (KPIC).

For assistance with questions regarding your coverage and benefits, please call Customer Service at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

This Evidence of Coverage (EOC) describes the Services covered by Health Plan that you receive from Plan Providers at Plan Facilities. The KPIC *Certificate of Insurance,* provided to you separately by KPIC*,* describes the Services covered by KPIC that you receive from participating and non-participating providers. KPIC coverage is not described in this EOC.

The benefits, Deductibles, Copayments, and/or Coinsurance for Health Plan and KPIC are not the same. Some Services may be covered by one health care option, but not the other. A covered Service will be covered by one of the options, but never by both. Neither Health Plan nor KPIC is responsible for a Member's decision to access care under this EOC or the KPIC *Certificate of Insurance*.

Amounts paid toward the Deductibles (if applicable) and Out-of-Pocket Maximum for Services received from Health Plan can be used to satisfy the Deductible and Out-of-Pocket Maximum for Services received in KPIC's participating provider tier. Also, amounts paid toward the Deductible and Out-of-Pocket Maximum for Services received from KPIC's participating provider tier can be used to satisfy the Deductible (if applicable) and Out-of-Pocket Maximum for Services received from Health Plan. Please refer to your KPIC *Certificate of Insurance* for a complete explanation.

Certain Services covered under your "3-Tier POS Plan" are limited to a combined maximum visit limit or day limit across the participating provider tier and the non-participating provider tier. See your KPIC *Certificate of Insurance* for more information about which Services have a combined benefit maximum limit.

Please note prescriptions obtained from any provider may be filled at Plan Pharmacies at the applicable Health Plan charge for medications on the Health Plan formulary; and routine lab and diagnostic X-ray orders obtained from any provider may be brought to Health Plan Facilities and will be charged at the applicable Health Plan benefit level.

When you access your Health Plan benefits covered under this EOC, you are selecting Kaiser Permanente's medical care program to provide your health care.

The following sections of your EOC are amended, as follows:

I. Section III. BENEFITS/COVERAGE (WHAT IS COVERED) is amended by *deleting***, in its entirety, the Subsection titled "Out-of-Area Benefit."** Any references to "Out-of-Area Benefit" in the "Schedule of Benefits (Who Pays What)", or anywhere else in this EOC, are also deleted in their entirety.

II. Section IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED), Subsection "A. Exclusions," is amended to read as follows:

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What Is Covered)" section. If a Service is not covered under this EOC, check your KPIC *Certificate of Insurance* to determine if it is covered by KPIC.

III. Section IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED), Subsection "C. Reductions, (1) Coordination of Benefits (COB)" is amended by *adding* **the following paragraph to this subsection:**

Note: The benefits administered by Health Plan as described in this EOC and the benefits administered by KPIC as described in your KPIC *Certificate of Insurance* are considered one plan for the purposes of coordination of benefits. Since a Service cannot be covered by both coverage options at the same time, there is no coordination of benefits between the two coverage options.

IV. Section VII. GENERAL POLICY PROVISIONS is amended by *adding* the following provision:

POS Coverage
Health Plan is not responsible for the obligations of KPIC nor for its decisions regarding KPIC claims and benefits. KPIC is not responsible for the obligations of Health Plan nor for our decisions regarding claims and benefits. Health Plan is not responsible for your decision to access Services from providers not contracting with us, the qualifications of these providers, or the Services they furnish. Furthermore, we are not liable for any act or omission of (1) such provider or the agents, officers, or employers of any of them, or (2) any other person or organization with which such providers have made or hereafter make arrangements for performance of Services.

V. The introductory paragraph of Section VIII. TERMINATION/NONRENEWAL/CONTINUATION is amended by *adding* the following paragraph:

If for any reason, you lose your KPIC coverage administered by KPIC, your Health Plan coverage described in this EOC will terminate on the same date. Check with your Group to discuss alternative health plan options.

VI. Section XI. DEFINITIONS is amended by *adding* the following definition:

Kaiser Permanente Insurance Company (KPIC): a California-domiciled insurance company licensed to conduct the business of insurance in Colorado and which underwrites the coverage for the Services that you receive from participating and/or non-participating providers of Kaiser Permanente's Point-of-Service (POS) plans. KPIC is a wholly owned subsidiary of Kaiser Foundation Health Plan, Inc.]

[

KAISER PERMANENTE®

IMPORTANT NOTICE

RE: Provider Network Information

Dear Kaiser Permanente Member:

Your plan uses the **KP Select** provider network. Please be sure to choose only providers marked as **KP Select** providers in the Kaiser Permanente Provider Directory. You can get a copy of the directory by calling **Member Services**. You can also get a list by visiting our website. Go to **kp.org**, then click on "Doctors & Locations." Choose **KP Select** on the "Health Plan" filter.**]**

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

CALL	**303-338-3800** 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.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

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**

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

Claims Department	
CALL	**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.

Delta Dental of Colorado	
CALL	Customer Relations **303-741-9305** or toll-free **1-800-610-0201** Monday-Friday, 8 a.m. to 6 p.m.
IVR	**1-800-610-0201** This number allows you to request a listing of dentists in your area and receive it by mail or fax.
WEBSITE	deltadentalco.com

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I. ELIGIBILITY

A. Who Is Eligible

1. General

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

   a. You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of the Group's eligibility requirements; and

   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and

   c. The Subscriber must live, work, or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

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

3. Dependents

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

   a. Your Spouse. (Spouse includes a partner in a valid civil union under state law).

   b. Your or your Spouse's children (including adopted children, children placed with you for adoption, and foster children) who are under the Dependent limiting age.

   c. Other dependent persons who meet all of the following requirements:
      i. They are under the Dependent limiting age; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

   d. Your or your Spouse's unmarried children over the Dependent limiting age who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.

   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

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

   See the "Schedule of Benefits (Who Pays What)" to determine if your Group has additional eligibility rules.

4. Health Savings Account Eligibility

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

B. Enrollment and Effective Date of Coverage

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

1. New Employees and their Dependents

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

2. Members Who are Inpatient on Effective Date of Coverage

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

3. Special Enrollment Due to Newly Acquired Dependents

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

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

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

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

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

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

   If you are enrolled in coverage directly through Health Plan, and you experience a decrease in household income and receive a new determination of eligibility for advance premium tax credit by Connect for Health Colorado, you will be eligible for a special enrollment period to enroll in coverage through Connect for Health Colorado.

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

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

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

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.

- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

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 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 Kaiser Permanente Medical Office Building. 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 Deductibles, 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. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

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 room 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 "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

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

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. 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.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to: prior Authorization; Deductible; Copayment; 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. 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.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

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

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (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 (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) Emergency Services, Urgent Care, certain Post Stabilization Care Services that qualify as Emergency Services (under applicable federal 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 (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- 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.

Essential Health Benefits are covered under this plan and include but are not limited to: chemotherapy Services; radiation therapy; oral anti-cancer medication; cardiac rehabilitation; nutritional counseling; smoking cessation programs; diabetes equipment and supplies; Pap test; annual prostate cancer screening; cervical cancer vaccines.

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

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

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

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

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

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis, and fetal stress tests performed during the office visit. Member may receive Services from a certified nurse midwife. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.

11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: 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 at the applicable office-administered drug Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.
    - 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); or
    - Allergy test and treatment materials.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

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

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).
2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram; sleep study; stress test; pulmonary function test; any treatment room; or direct admission to any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service 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. Charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

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

D. Alternative Medicine

1. Chiropractic Care
   a. Coverage
      We cover chiropractic care Services as shown in the "Schedule of Benefits (Who Pays What)" when provided by contracted providers. You may self-refer for visits to Plan Providers. Coverage includes:
      i. Evaluation;
      ii. Manual and manipulative therapy of the spinal and extraspinal regions.

      Note: The following are covered, but not under this section: Physical therapy, see "Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services"; X-ray and laboratory tests, see "X-ray, Laboratory, and Advanced Imaging Procedures."

   b. Chiropractic Care Exclusions
      i. Hypnotherapy.
      ii. Behavior training.
      iii. Sleep therapy.
      iv. Weight loss programs.
      v. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
      vi. Vocational rehabilitation Services.
      vii. Thermography.
      viii. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
      ix. Transportation costs. This includes local ambulance charges.
      x. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
      xi. Educational programs.
      xii. Non-medical self-care or self-help training.
      xiii. All diagnostic testing related to these excluded Services.
      xiv. MRI and/or other types of diagnostic radiology.
      xv. Massage therapy that is not a part of the manual and manipulative therapy.
      xvi. Durable medical equipment (DME) and/or supplies for use in the home.

2. Acupuncture Services
   a. Coverage
      We cover acupuncture Services as shown in the "Schedule of Benefits (Who Pays What)" when provided by contracted acupuncturists and if clinically appropriate. You may self-refer for visits to contracted acupuncturists. Coverage includes treatment for:
      i. Neuromusculoskeletal pain due to an injury or illness; or
      ii. Allergy, asthma, nausea, or vomiting.

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

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

   b. Acupuncture Services Exclusions
      i. Rental or purchase of durable medical equipment (DME).
      ii. Air purifiers, therapeutic mattresses, supplies, or similar devices, appliances, or equipment. Their use or installation does not have to be for therapy or easy access.
      iii. Radiology and laboratory tests.
      iv. Prescription drugs, vitamins, herbs, or food supplements. It does not matter if they are prescribed or recommended by a contracted acupuncturist.
      v. Massage or soft tissue techniques that are not part of the acupuncture treatment, except acupressure.
      vi. Treatment mainly for obesity or weight control.
      vii. Vocational, stroke, or long-term rehabilitation.
      viii. Hypnotherapy.
      ix. Behavior training.
      x. Sleep therapy or biofeedback.
      xi. Acupuncture Services provided for maintenance or preventive care Services.

xii. Expenses for acupuncture Services provided during visits that exceed your visit limit.
xiii. Expenses for any Services provided before coverage begins or after coverage ends for this benefit.
xiv. Any Services provided by an acupuncturist who is not contracted. It does not matter if the Services are obtained in or out of the Health Plan's Service Area.
xv. Acupuncture Services that Kaiser Permanente determines are not clinically appropriate in its utilization review. (Members may not be surcharged for such Services.)
xvi. Services not authorized by Kaiser Permanente. This exclusion does not apply to the initial evaluation.
xvii. Any techniques or procedures not generally accepted in a majority of state acupuncture licensing boards.
xviii. Benefits, items, or Services that are limited or excluded in the EOC, unless changed by this benefit.

3. Massage Therapy
Note: To determine if this benefit is covered, see the "Schedule of Benefits (Who Pays What)."

E. Ambulance Services and Other Transportation

1. Coverage
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.

F. Bariatric Surgery

1. Coverage
We cover Medically Necessary bariatric surgery as shown in the "Schedule of Benefits (Who Pays What)." You must meet Utilization Management Program Criteria to be eligible for coverage.

2. Bariatric Surgery Exclusion
Cosmetic surgery or other cosmetic Services or supplies related to bariatric surgery.

G. Clinical Trials

1. Coverage
a. We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.
b. We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
i. We would have covered the Services if they were not related to a clinical trial.
ii. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
(A) A Plan Provider makes this determination.
(B) You provide us with medical and scientific information establishing this determination.
iii. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
iv. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
(A) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
(B) The study or investigation is a drug trial that is exempt from having an investigational new drug application.
(C) The study or investigation is approved or funded by at least one of the following:
(1) The National Institutes of Health.
(2) The Centers for Disease Control and Prevention.
(3) The Agency for Health Care Research and Quality.
(4) The Centers for Medicare & Medicaid Services.
(5) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
(7) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
(a) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
(b) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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

2. Clinical Trials Exclusions
a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

H. Dental Services

We cover certain dental Services for Members through Delta Dental of Colorado. This benefit is covered only if you visit a Delta Dental PPO dentist. If you receive treatment from a non-PPO dentist, you will not receive benefits and you will be responsible for all fees charged by the non-PPO dentist.

1. Adult Dental Services
We cover limited dental Services for Members age nineteen (19) years and over. If you are under age 19 when you enroll in this plan, Adult Dental Services begin on the first of the month following your 19th birthday. This benefit is subject to the frequencies and limitations shown in the "Schedule of Benefits (Who Pays What)." You are responsible for the applicable Copayment.

2. Pediatric Dental Services
The dental coverage is part of your medical plan. It is provided only up to the end of the month you turn age 19. Members can receive any of the procedures listed in the "Schedule of Benefits (Who Pays What)" during the Accumulation Period.

You are responsible to pay the Deductible and any Coinsurance under this benefit. Your Accumulation Period dollar maximum benefit is unlimited. However, this benefit is subject to the frequencies and limitations shown in the "Schedule of Benefits (Who Pays What)."

How to Find a Dentist:
There are two (2) easy ways that you can find out if your dentist is a **PPO participating dentist** with Delta Dental.

- **Website**: You may log onto the Delta Dental web page at deltadentalco.com and use the Find a Dentist feature. This feature allows you to search by city and state or zip code and provides a listing of dentists in your area.
- **Integrated Voice Response (IVR)**: Delta Dental's IVR allows you to call and request a listing of dentists in your area and receive it by mail or fax. Call 1-800-610-0201 and follow the prompts.

If you have questions about this dental coverage, please call Delta Dental's **Customer Relations** at 303-741-9305 or 1-800-610-0201 (toll free), Monday-Friday, 8 a.m. to 6 p.m.

I. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:
1. The Services are provided inside our Service Area; and
2. You meet 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: equipment; training; and medical supplies required for home dialysis.

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

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

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, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown in the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed.

Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge.

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

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

1. Durable Medical Equipment (DME)
   a. Coverage:
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes but is not limited to: infant apnea monitors; insulin pumps and insulin pump supplies; and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps, insulin pump supplies, and continuous glucose monitors are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Oxygen and oxygen dispensing equipment. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

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

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

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

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

3. Orthotic Devices

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

b. Orthotic Devices Exclusions
i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract. For Members under age 19 see "Pediatric Dental Services" in this "Benefits/Coverage (What Is Covered)" section.
iii. Experimental and research braces.
iv. More than one orthotic device for the same part of the body, except for covered replacements.
v. Spare devices or alternate use devices.
vi. Replacement of lost or stolen orthotic devices.
vii. Repairs, adjustments or replacements necessitated by misuse.

K. Early Childhood Intervention Services

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

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

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

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

L. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition 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 EOC. 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 room 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. 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," below, if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:
   A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan 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 does 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. any applicable Deductible, Copayment, and/or Coinsurance for Emergency Services and advanced imaging procedures performed in the emergency room. The emergency room and advanced imaging procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Deductible, Copayment, and/or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and
v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
vi. amounts you or your legal representative recover from motor vehicle insurance or because of third party liability.

Note: 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. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, **kp.org**, for information on designated urgent care facilities.

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

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

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

M. Family Planning and Sterilization Services

We cover the following:

1. Family planning counseling. This includes counseling and information on birth control.
2. Tubal ligations.
3. Vasectomies.

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 "Prescription Drugs, Supplies, and Supplements."

N. Gender Affirming Health Services

We cover gender affirming health Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Health Plan will not deny, exclude, or otherwise limit coverage for medically necessary services, in accordance with generally accepted professional standards of care, based upon your sexual orientation or gender identity. 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.
f. Inpatient and outpatient hospital care.
g. Treatment for complications of surgery.
h. Voice therapy lessons.

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 and/or testicular prosthesis; urethral extension; bilateral mastectomies; chest reconstruction; breast reduction; blepharoplasty (eye and lid modification); face/forehead and/or neck tightening; rhytidectomy (cheek, chin, and neck); cheek, chin, nose implants; lip lift/augmentation; mandibular angle augmentation/creation/reduction (jaw); orbital recontouring; rhinoplasty (nose reshaping); salpingectomy; vulvectomy; trachelectomy; perineum reconstruction; liposuction; lipofilling; nipple reconstruction.
   ii. **Assigned male at birth**: penectomy; vaginoplasty (includes vaginal dilator); clitoroplasty; labiaplasty; orchiectomy; breast augmentation; tracheal shave; blepharoplasty (eye and lid modification); face/forehead and/or neck tightening; facial bone remodeling for facial feminization; genioplasty (chin width reduction); rhytidectomy (cheek, chin, and neck); cheek, chin, nose implants; lip lift/augmentation; mandibular angle augmentation/creation/reduction (jaw); orbital recontouring; rhinoplasty (nose reshaping); vulvoplasty; urethroplasty; vaginal/perineum reconstruction; liposuction; lipofilling .
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. Pectoral implants.
   d. Permanent hair implantation/hair reconstruction.
   e. Voice modification surgery.
   f. Any and all Services, procedures, supplies, office administered drugs, and prescription drugs received from the pharmacy related to the procurement, transfer, and/or storage (including cryopreservation) of semen, sperm, eggs, reproductive materials, and/or embryos.
   g. Prostatectomy.
   h. Gluteal Augmentation (implants/lipofilling).

O. Health Education Services

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

P. Hearing Services

1. Members up to Age 18
   a. Hearing Exams and Tests
      We cover hearing exams and tests to determine the need for hearing correction.

   b. For Minor Children with a Verified Hearing Loss
      Coverage shall also include:
      i. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
      ii. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
      iii. Services and supplies including, but not limited to: the initial assessment; fitting; adjustments; and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and 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.
iii. Services relating to fitting and adjustment of hearing aids.

Q. Home Health Care

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 (i.e., urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

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.

R. Hospice Special Services and Hospice Care

1. Hospice Special Services

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

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

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

2. Hospice Care

We cover hospice care for terminally ill Members inside our Service Area. If a Plan 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, care for pain control, and acute and chronic pain management.
i. Counseling and bereavement Services.
j. Services of volunteers.

S. 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. Outpatient Therapy
      i. We cover individual office visits and group office visits. Psychological testing as part of diagnostic evaluation is covered.
      ii. We cover partial hospitalization and intensive outpatient therapy.
      iii. We cover visits for the purpose of monitoring drug therapy.

   b. Inpatient Services

      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 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.

   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, Medically Necessary and appropriate.
   b. Custodial Care, as defined in "Exclusions" under "Limitations/Exclusions (What is Not Covered)."

T. Out-of-Area Benefit

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

1. Coverage

   The Out-of-Area Benefit is limited to certain office visits; diagnostic X-rays; physical, occupational, and speech therapy; and prescription drug fills as covered under this EOC:

   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

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

2. Out-of-Area Benefit Exclusions and Limitations

   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but **not limited** to: procedures; laboratory tests; and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).

e. Allergy evaluation; routine prenatal and postpartum visits; chiropractic care; acupuncture services; applied behavior analysis (ABA); dental services; hearing tests; hearing aids; home health visits; hospice services; and travel immunizations.
f. Breast cancer screening and/or imaging.
g. Ultrasounds.
h. Advanced imaging procedures, including but not limited to: CT; PET; MRI; nuclear medicine.
i. Any and all Services not listed in the "Coverage" section of this benefit.

U. 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
We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

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

c. Inpatient Rehabilitation Services
We will cover treatment while you are in a designated inpatient rehabilitation facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational, and speech therapy Coinsurance.

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

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

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

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

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

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

V. Prescription 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**.

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

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible and supply limits that apply to the covered prescription drugs described below. If your prescription drug has a Copayment shown in the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

For outpatient prescription drugs and/or items that are covered under the "Prescription 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 or Coinsurance that you owe, after you satisfy your plan's required Deductible, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire Copayment or Coinsurance for your prescription. When you use an approved coupon for payment of the Copayment or Coinsurance, the coupon amount and any additional payment that you make will accumulate to the Out-of-Pocket Maximum. 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**.

You must meet your medical Deductible before any prescription drug benefit is paid by Health Plan. Once the Deductible has been met, you will pay the lesser of: your applicable prescription drug Copayment; or Coinsurance; or the drug cost.

1. Coverage

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

   a. Outpatient Prescription Drugs

      The following drugs are available only when prescribed by a Plan Provider, provider to whom a Member has been referred by a Plan Provider, or dentist (when prescribed for acute conditions), and obtained at Plan Pharmacies:

      i. Drugs for which a prescription is required by law.
      ii. Insulin. You are not responsible for more than $100 per thirty-day supply of all covered prescription insulin drugs.
      iii. Off-label use of cancer drugs.
      iv. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
      v. 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.
      vi. 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.
      vii. Oral anti-cancer medications.

      The amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any amount that exceeds that limit. For some drugs, you can get up to a 90-day supply when you fill your prescription at a pharmacy inside a Kaiser Permanente Medical Office Building. Your normal Copayment or Coinsurance will apply for each supply limit you receive, as shown in the "Schedule of Benefits (Who Pays What)." If your prescription drug has a Copayment, you may pay less if you get a 90-day supply from our mail order pharmacy.

      Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. 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. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

      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 the brand-name

Copayment or Coinsurance, 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 the applicable Copayment or Coinsurance.

b. 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.

iii. We cover all eighteen (18) forms of emergency and preventative contraception approved by the FDA at no-cost to the consumer and included in the Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines. These include, tubal ligation, various intrauterine devices (IUDs), implants, shots, oral contraceptives (sometimes known as "the pill"), patches, vaginal rings, diaphragms, sponges, cervical caps, female condoms, spermicide, and emergency contraceptives (sometimes known as "Plan B"). The no-cost coverage also includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., office visits, management, evaluation, associated laboratory testing, as well as changes to and removal or discontinuation of the contraceptive method).

   We cover twelve (12) months of a prescription contraceptive at one time.

   While We may utilize certain medical management techniques to prioritize coverage of one medication or item in the same category, it does not use the following techniques, as they create unreasonable delay: Denial of coverage for all or particular brand name contraceptives, fail-first or step therapy requirements, and age limitations on coverage.

   If you require a different type of contraception, we will cover, without cost to the member, any necessary contraceptive service or item, and the Health Plan will defer to your provider's determination. We have an exceptions process to request a different type of contraception that is easily accessible, transparent, sufficiently expedient, and not unduly burdensome on You or your provider. More information about the exceptions process can be found here: **kp.org/co/medicationexception**

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

c. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs 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**.

d. Specialty Drugs

Prescribed specialty drugs, such as self-administered injectable drugs, are provided at the applicable drug Copayment or Coinsurance up to the maximum amount per drug dispensed.

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:

i. home glucose monitoring supplies;

ii. disposable syringes for the administration of insulin;
iv. glucose test strips;
v. acetone test tablets; and
v. nitrate screening test strips for pediatric patient home use.

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 when prescribed and dispensed by a pharmacist.

      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. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law, except for those listed in the "Schedule of Benefits (Who Pays What)."
   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. Certain drugs determined excluded by the KPCO Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Drugs available over the counter and by prescription for the same strength except as required and defined under the Patient Protection and Affordable Care Act.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services."
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."
   q. Continuous Glucose Monitors. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."

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

W. Preventive Care Services

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

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

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

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

1. Office visits for preventive care Services.
2. Mental health wellness examination.
3. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
4. Cervical cancer screening.
5. Breast cancer screening in accordance with state law.
6. Cholesterol screening.
7. Blood pressure screening.
8. Colorectal cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Prostate cancer screening.
14. Cervical cancer vaccines.
15. Influenza and pneumococcal vaccinations.
16. Approved Affordable Care Act contraceptive categories.
17. HIV infection prevention drugs, including baseline and monitoring Services.
    a. We will cover federal Food and Drug Administration (FDA)-approved HIV PrEP medication prescriptions without copayment or cost-sharing if your provider or pharmacist determines that you are indicated for PrEP. Coverage will include baseline and monitoring services consistent with USPSTF recommendations without copayment or cost-sharing. Prior authorization for HIV PrEP medication from a non-pharmacist provider will be processed on an urgent basis within 24 hours of receipt.

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

X. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a

symmetrical appearance and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

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

Y. Reproductive Support Services

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 as shown in the "Schedule of Benefits (Who Pays What)":
   a. Office visits, X-ray and laboratory tests.
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

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. Reproductive Support 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. Any and all Services, supplies, office administered drugs, and prescription drugs received from the pharmacy related to the procurement, transfer, and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from the pharmacy for reproductive support Services.
   f. 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.

Z. Skilled Nursing Facility Care

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-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products and their administration.

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

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment (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 "Limitations/Exclusions (What is Not Covered)."

AA. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

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

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

3. Outpatient Services
   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.

BB. 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; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.
   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.
   c. If all 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.

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 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. The 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 EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations when 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 Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

CC. Vision Services

1. Coverage
   a. Up to the End of the Calendar Year the Member Turns Age 19
      We cover routine eye exams and refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses. We cover prescribed vision hardware (eyeglasses and lenses) once every two (2) years, or a two-year supply of contact lenses, as shown in the "Schedule of Benefits (Who Pays What)."

   b. Members Age 19 Years and Over
      We cover routine eye exams and refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses. Vision hardware and contact lenses are not covered.

   For all eligible Members, we also cover professional exams for a specific medical condition. This includes the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames for Members age 19 years and over.
   b. Cosmetic or specialty options such as: tints; trifocals; mirror coating; polarization; and progressive lenses.
   c. Contact lenses for Members age 19 years and over.
   d. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   e. 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.
   f. Eyewear for protection, including but not limited to: industrial eyewear; safety eyewear; athletic safety eyewear; or eyewear required as a condition of employment.
   g. 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).
   h. Orthoptic (eye training) therapy or low vision therapy.
   i. Replacement of lost or stolen eyewear.

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

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, ultrasounds, and mammograms.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      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 Services is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. Advanced imaging procedures including, but not limited to: MRI; CT; PET; and nuclear medicine.
      Note: For advanced imaging procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Deductible, Copayment, and/or Coinsurance for advanced imaging procedures performed as part of or in conjunction with other outpatient Services including but not limited to Emergency Services, urgent care, and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services, and materials including, but not limited to: diagnostic and therapeutic X-rays and isotopes; electrocardiograms; electroencephalograms; ultrasounds; MRI; CT; PET; and nuclear medicine are covered under your hospital inpatient care benefit.

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.

[PLUS BENEFIT WITH PRESCRIPTION DRUGS

You may see an Out-of-Plan Provider for limited covered Services. You may receive covered Services from an Out-of-Plan Provider either inside or outside our Service Area. You do not need a referral or prior Authorization to see an Out-of-Plan Provider for these Services.

If you have questions about your Plus Benefit, please call **Customer Service** at **1-855-364-3184** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m., Mountain time.

1. Coverage

   The Plus Benefit coverage is limited to certain benefits as covered under this EOC.

   a. Office visit exam charge limited to:
      i. Preventive and well-child visits.
      ii. Primary care visits, including email, online chat, telephone visits, or video visits.
      iii. Specialty care visits, including email, online chat, telephone visits, or video visits.
      iv. Gynecology care visits.
      v. Hearing exams.
      vi. Mental health visits.
      vii. Substance use disorder visits.
      viii. Physical, occupational, and speech therapy visits.
      ix. Allergy evaluation and testing visits.
   b. Visits with the administration of allergy injections.
   c. Covered Services performed during physician office visit including implantable and injectable contraceptives.
   d. Laboratory Services.*
   e. Diagnostic X-ray.*
   f. Durable Medical Equipment (DME) **dispensed** during your office visit.*
   g. Prescriptions dispensed at an Out-of-Plan Pharmacy when prescribed by an Out-of-Plan Provider.**

   For each covered Service listed above, you will be charged the appropriate Deductible, Copayment, and/or Coinsurance. Please refer to the "Schedule of Benefits (Who Pays What)" for Deductibles, Copayments, Coinsurance, and the annual maximum limit that applies.

   *If you choose to have these procedures performed at a Plan Facility, your Plan coverage will apply. You may also choose to have DME dispensed by a Plan Provider. Your Plan coverage will apply to DME dispensed by a Plan Provider.

   **You may choose to have prescriptions from an Out-of-Plan Provider filled at a Plan Pharmacy. Prescriptions filled at a Plan Pharmacy will not count toward your annual prescription drug limit for Plus Benefit Services. For prescriptions filled at a Plan Pharmacy, your Group's Plan coverage will apply. See the "Schedule of Benefits (Who Pays What)" for Deductibles, Copayments, and/or Coinsurance that apply to Prescription Drugs, Supplies, and Supplements.

   Note: Prescriptions prescribed by a Plan Provider must be filled by a Plan Pharmacy.

   In addition to any Deductible, Copayment, and/or Coinsurance, you are responsible for any amounts that exceed eligible Charges. Out-of-Plan Providers may bill you for the amount that is greater than what we are required to pay, and you are financially responsible for this amount.

2. Limits

   Limits accumulate as follows:

   a. Each office visit counts as one visit or service. This includes any covered Service performed during an office visit other than diagnostic X-ray or laboratory Services.
   b. Each diagnostic X-ray counts as one visit or service.
   c. All laboratory Services done by the same provider in the same day count as one visit or service.
   d. Each DME item dispensed during an office visit counts as one visit or service.
   e. Each prescription filled at an Out-of-Plan Pharmacy counts as one fill toward the prescription drug fill maximum.

   Example 1: If you have an office visit with an Out-of-Plan Provider and also have laboratory Services from an Out-of-Plan Provider, the total visit and service count would be two.

   Example 2: If you have an office visit with an Out-of-Plan Provider and also have a diagnostic X-ray of the hand and a diagnostic X-ray of the wrist from an Out-of-Plan Provider, the total visit and service count would be three.

   Example 3: If you have an office visit with an Out-of-Plan Provider and you choose to have a diagnostic X-ray performed at a Plan Facility, the total visit and service count would be one.

   Example 4: If you have an office visit with an Out-of-Plan Provider and the provider dispenses a DME item during that visit, the total visit and service count would be two.

Example 5: If you have an office visit with an Out-of-Plan Provider and the provider writes a prescription which you choose to fill at an Out-of-Plan Pharmacy, the total visit and service count would be one applied to your annual maximum limit and one prescription applied to your annual prescription drug fill maximum for Plus Benefit Services.

3. Limitations
   a. Services provided outside of the Health Plan must meet all Plan provisions and be covered Services under this EOC in order to be eligible for the Plus Benefit.
   b. You may be asked to pay your provider the full amount of Charges at the time of your visit. In this situation, you will need to submit a claim form for reimbursement. Health Plan will reimburse you for the full cost of your visit up to the eligible Charges, minus your Deductible, Copayment, and/or Coinsurance amount. To request claim forms, please call **Customer Service**. Out-of-Plan Providers may bill you for the amount that is greater than what we are required to pay, and you are financially liable for this amount.
   c. If you choose to fill a prescription at an Out-of-Plan Pharmacy, you will need to submit a receipt to the Claims Department for review, processing, and reimbursement.
   d. After you reach the Plus Benefit annual maximum limit, you will be responsible for any Charges for out-of-Plan Services.

4. Plus Benefit Exclusions

   Services excluded from the Plus Benefit include, but may not be limited to:
   a. Hospital Services (inpatient or outpatient).
   b. Any Services provided while in a hospital, Skilled Nursing Facility, or free-standing surgical center.
   c. Out-of-Plan Facility fees.
   d. Acupuncture Services.
   e. Chiropractic Services.
   f. Massage therapy.
   g. Applied behavior analysis (ABA) for the treatment of autism spectrum disorders.
   h. Routine prenatal and postpartum visits.
   i. Dialysis.
   j. Oxygen.
   k. Bariatric Surgery.
   l. Genetic Testing.
   m. Infertility.
   n. Home Health Care.
   o. Hospice Care.
   p. Dental Services.
   q. Office administered drugs.
   r. Partial hospitalization and intensive outpatient therapy.
   s. Breast cancer screening and/or imaging.
   t. Therapeutic X-ray Services.
   u. Transplant Services.
   v. Screening colonoscopies.
   w. Professional exams for fitting and dispensing of contact lenses.
   x. Advanced imaging procedures, including but not limited to CT; PET; MRI; and nuclear medicine.
   y. Any and all Services not listed in the "Coverage" section of this benefit.]

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

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

1. **Alternative Medical Services.** See the "Schedule of Benefits (Who Pays What)" to determine if Alternative Medicine is covered. Otherwise, the following are not covered:
   a. Naturopathy Services.
   b. Massage therapy.

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

3. **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.

4. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result

in significant improvement in physical function. This includes cosmetic services related to bariatric surgery. Exceptions: Medically Necessary Services covered under "Reconstructive Surgery" and "Gender Affirming Health Services" in the "Benefits/Coverage (What is Covered)" section.

5. **Cosmetic Surgery Related to Bariatric Surgery.**

6. **Cryopreservation.** Any and all Services related to cryopreservation, including but 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) Services described in the "Dental Services" section; (b) 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 (c) 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 (d) 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, (b) and (c) 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/Coverage (What is Covered)" section or the prescription drug benefit description.

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 Technologies Committee, 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.

Note: This exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

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

[

29. **Abortion.**
    a. Voluntary, elective abortions and any related Services are excluded.
    b. Therapeutic abortions performed when the pregnancy is the result of an act of rape or incest are excluded.

30. **End-of-Life Drugs.** This plan does not cover prescriptions for the lethal drug and accompanying drugs written according to Colorado's End-of-Life Options Act.]

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan 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. Coordination of Benefits (COB)

   Please note that because you are enrolled in a Kaiser Permanente HSA-Qualified Deductible HMO Plan, if you have other health care coverage in addition to this coverage, in most instances you will not be eligible to establish or contribute to an HSA unless both coverages qualify as High Deductible Health Plans. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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

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

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

DEFINITIONS

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

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

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

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.
   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

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

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.
   ii. If a person is covered by two (2) or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
   iii. If a person is covered by two (2) or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
   iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
   v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

ORDER-OF-BENEFIT DETERMINATION RULES

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

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

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

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

d. Each **Plan** determines its order-of-benefits using the first of the following rules that applies:

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

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering the **non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

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

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

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, any recovery you receive from: (a) uninsured

motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage; or (f) any responsible party or entity.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against 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.

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

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

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

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

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

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

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

3. Traditional or Gestational Surrogacy

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 a woman 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 "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

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

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives

- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

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

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.

V. MEMBER PAYMENT RESPONSIBILITY

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

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from 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 Deductibles, Copayments or Coinsurance amounts, 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 defines 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).

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

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

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

VII. GENERAL POLICY PROVISIONS

A. Access Plan

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

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan 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 we arrange or provide will be at no charge to the Member.

C. Administration of Agreement

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

D. Advance Directives

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

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

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

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

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

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

E. Agreement Binding on Members

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

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. Your Group or Health Plan will notify you at least 60 days prior to the effective date of the change. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

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

H. Assignment

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

I. Attorney Fees and Expenses

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

J. Claims Review Authority

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

K. Contracts with Plan Providers

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

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from 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 Deductibles, Copayments, and/or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

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

L. Deductible/Out-of-Pocket Maximum Takeover Credit

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

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

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

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

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

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

M. 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.

N. Governing Law

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

O. Group and Members not Health Plan's Agents

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

P. No Waiver

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

Q. Nondiscrimination

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

R. Notices

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

S. Overpayment Recovery

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

T. Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. 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) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* 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.

U. Value-Added Services

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

1. Certain non-covered 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.

V. Women's Health and Cancer Rights Act

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

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

VIII. TERMINATION/NONRENEWAL/CONTINUATION

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

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

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in section I, we or your Group will provide 30 days' advance written notice of termination and include the reason for termination.

B. Termination of Group Agreement

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

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

C. Termination for Cause

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

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or

   b. You fail to establish and maintain a satisfactory provider-patient relationship after the Plan Provider has made reasonable efforts to promote such a relationship.

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent enrollment eligibility information or membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or

   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

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

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

D. Termination for Nonpayment

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

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

E. Termination of a Product or all Products

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

F. Rescission of Membership

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

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

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

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

1. Federal Law (COBRA)

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

2. State Law

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

   a. Your coverage is through a Subscriber who dies, divorces or legally separates or becomes entitled to Medicare or Medicaid benefits; or

   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

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

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 calendar days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

   a. 18-months after your coverage would have otherwise terminated because of termination of employment; or

   b. The date you become covered under another group medical plan; or

   c. The date Health Plan terminates its contract with the Group.

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

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

3. USERRA

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

H. Moving Outside of our Service Area

If you move outside of our Service Area, you should contact your Group's benefits administrator. If you no longer live, work, or reside in our 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.

I. Moving to Another Kaiser Regional Health Plan Service Area

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

J. Conditions for Renewability

We will renew or continue your coverage, at your option, unless:

1. you fail to pay the required Premiums or fail to pay Premiums timely;
2. you or your representative perform an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of coverage;
3. in the case of a plan that is made available only through one or more bona fide associations, your membership in the association on the basis of which your coverage is provided ceases, but only if the coverage is terminated uniformly without regard to any health-status-related factor relating to any covered person;
4. we decide to discontinue offering this plan, in which case we will provide notice to you of the decision not to renew at least ninety (90) days before the nonrenewal; will offer you the option to purchase any other health benefit plan currently offered by us in this state; and provide information on the special enrollment periods;
5. we elect to discontinue offering and renewing all of our health benefits plans in this state, in which case we will provide notice to you of the decision to discontinue coverage at least one hundred eighty (180) days before the discontinuance. If such discontinuance occurs, we will continue to provide coverage through the first renewal period not to exceed twelve (12) months after the notice to you of the discontinuance.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

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

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).
2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, 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 membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   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 EOC, 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 "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

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 may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

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

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal, 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 the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

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

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

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

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

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

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you 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 the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 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.

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 days after we receive your appeal.

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

c. Urgent Pre-Service Appeal

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

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

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you 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 to be provided over 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 **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you 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 or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends (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 the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 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.

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

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

c. Urgent Concurrent Care Appeal

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

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

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you 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 the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 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.

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

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

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

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

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

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

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

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

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:

Member Services
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 decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that (1) is a denial of a preauthorization for a Service; (2) is 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) is 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 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 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 the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.

2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

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

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have 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. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described above).

Additional Requirements for External Review regarding Experimental or Investigational Services

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

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

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

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

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

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

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law.

You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

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

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

Additional Review

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

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan 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:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

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

3. If you are dissatisfied with the resolution, you have the right to request a second review.

   Please put your request in writing to **Member Services.**

   Member Services will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan 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**.

X. INFORMATION OF POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group or Health Plan will notify you at least 60 days prior to the effective date of the change. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

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

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted 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 provider covered Services to Members under this EOC. 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.

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 or 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 as 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 "Schedule of Benefits (Who Pays What)."

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

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

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

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 the individual or, with respect to a pregnant woman, the health of the woman or her 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 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 requires 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 applies and defines such Post Stabilization Care as Emergency Services.

Family Unit: A Subscriber and all of their Dependents.

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

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

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

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

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 EOC.

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 EOC, and for whom we have received applicable Premiums. This EOC 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 amount of Deductible, certain Copayments, and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A 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 EOC. 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 (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 paid by Group.

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 are designated 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 woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

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

Subscriber: A Member who is eligible for membership on 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" section.

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

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