Important Benefit Information Enclosed

Evidence of Coverage

2020 SCHEDULE OF BENEFITS

This Schedule of Benefits is a brief summary of coverage for eligible Members. For more detailed information, contact **Member Services** at **303-338-3800** or toll-free at **1-800-632-9700** or TTY **711**. (These benefits and Services are covered only when Medically Necessary and provided or prescribed by a Plan Physician.)

		PLAN 201	**PLAN 202**	**PLAN 203**	**PLAN 204**
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Outpatient Care	Primary care visits: Services from family practice, internal medicine, pediatrics	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Specialty care visits: Services from providers that are not primary care	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Office administered drugs	$0	$0	$0	$0
	Virtual care services: • Chat with a doctor online via kp.org • Email • Telephone visits • Video visits	 $0 $0 $0 $0	 $0 $0 $0 $0	 $0 $0 $0 $0	 $0 $0 $0 $0
	Outpatient surgery at designated outpatient facilities	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit

Note: Some participants may qualify for no cost sharing and will be automatically enrolled in Plan 200.

		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Outpatient Care	Preventive Services: • Health maintenance visits • Well child and well baby visits • Behavioral health screening • Immunization visits • Routine screenings such as blood cholesterol and Pap smears • Flexible sigmoidoscopy screening (or screening colonoscopy when ordered by your Plan Physician) • Screening mammograms and clinical breast exams • Prostate screening • Eye wellness exams	$0	$0	$0	$0
Ambulance Service	Covered only if Member's condition requires medical Services that only a licensed ambulance can provide	$0	$2 Copay per trip	$15 Copay per trip	$25 Copay per trip
Emergency Services	In-Plan and out-of-Plan Emergency Rooms Covered 24 hours a day	$3 Copay each visit Waived if admitted as an inpatient	$3 Copay each visit Waived if admitted as an inpatient	$30 Copay each visit Waived if admitted as an inpatient	$50 Copay each visit Waived if admitted as an inpatient
Urgent Care	Urgent care received at Plan facilities	$1 Copay each visit	$1 Copay each visit	$20 Copay each visit	$30 Copay each visit

		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hospital Inpatient Care (No limit on covered days)	Room and Board and Critical Care Units Intensive care and related hospital Services General nursing care Other hospital Services and supplies such as: • Lab, X-ray, and other diagnostic Services • Prescribed drugs and medicines • Dressings, splints, casts, and sterile tray Services • Anesthetics • Professional Services of physicians and other health care providers	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
Maternity Care	Outpatient: Prenatal and postpartum visits	$0	$0	$0	$0
	Inpatient: Physician and hospital Services	$0 for delivery of baby and inpatient well-baby care			

		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Drugs, Supplies, and Supplements	Outpatient prescription drugs Copayment (except as listed below):	$0	$1 Generic $1 Brand name	$3 Generic $10 Brand name	$5 Generic $15 Brand name
	• Prescription contraceptives	$0	$0	$0	$0
	• Prescribed supplies	$0	$1 Generic $1 Brand name	$3 Generic $10 Brand name	$5 Generic $15 Brand name
	• Infertility drugs	Not Covered			
	• Sexual dysfunction drugs	Not Covered			
	• Travel immunizations	Not Covered			
		SUPPLY LIMIT			
	Day supply limit	30-day supply			
	Mail-order supply limit	90 days @ 2 Copayments			

		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Durable Medical Equipment (DME) and Prosthetics and Orthotics	Durable medical equipment	$0	$0	$0	$0
	Prosthetic devices	$0	$0	$0	$0
	• Internally implanted prosthetic devices	See Hospital Inpatient Care or Outpatient Care	See Hospital Inpatient Care or Outpatient Care	See Hospital Inpatient Care or Outpatient Care	See Hospital Inpatient Care or Outpatient Care
	Orthotic devices	$0	$0	$0	$0
	Oxygen	$0	$0	$0	$0
	Annual combined maximum benefit paid by Health Plan for the items listed above	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
	Prosthetic arm or leg	$0	$0	$0	$0
Hearing Services	Hearing exams and tests to determine the need for hearing correction through age 18	$0	$0	$0	$0
	Hearing aids for persons through age 18	$0	$0	$0	$0

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		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Mental Health	Outpatient: • Individual therapy visits • Partial hospitalization	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Inpatient: Hospital and facility Services for psychiatric conditions	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
	Residential Care: Treatment in a Plan hospital-based program	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
Substance Use Disorder	Outpatient: • Outpatient Services for treatment of alcohol and drug dependency • Partial hospitalization	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Inpatient: Diagnosis, medical treatment including medical detoxification, and referral Services	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
	Residential rehabilitation: Inpatient Services in a residential rehabilitation program	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission

		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Physical, Occupa-tional, and Speech Therapy	Rehabilitation outpatient therapy: limited to 30 visits per year, any combination of physical, occupational, or speech therapy • Visit limit not applicable to therapy visits for developmental delays age 0 up to 3rd birthday • Visit limit not applicable to speech therapy for cleft lip/cleft palate	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Applied Behavior Analysis (ABA) therapy	Not Covered			
	Inpatient rehabilitation: Limited to 30 days per year	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
Skilled Nursing Facility Care	Limited to 30 days per calendar year for Members who need skilled nursing care 24 hours a day. Custodial care is not covered.	$0	$0	$0	$0
Home Health Care	Health Services provided in your home and prescribed by a Plan Physician. Home health Services are medically necessary part-time or intermittent Services.	$0	$0	$0	$0
Hospice Care	For terminally ill patients with life expectancy of 6 months or less	$0	$0	$0	$0

		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Vision Services and Optical	Routine eye exam and refraction test: Limited to 1 per year	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Optical hardware	**Credit** $50 credit every 12 months			
X-rays, Lab, and X-ray Special Procedures	Diagnostic laboratory Services	$0	$0	$5 Copay	$10 Copay
	Diagnostic X-ray Services	$0	$0	$5 Copay	$10 Copay
	Therapeutic X-rays	$0	$0	$0	$0
	X-ray special procedures such as CT, PET, MRI, nuclear medicine	$0	$0	$5 Copay per scan	$10 Copay per scan
Out-of-Pocket Maximum	This limit is based on Services received during the current calendar year.	Five percent (5%) of annual family gross income	Five percent (5%) of annual family gross income	Five percent (5%) of annual family gross income	Five percent (5%) of annual family gross income

All benefits are subject to the exclusions and limitations listed in the Exclusions and Limitations section of this EOC.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – 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.

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**

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	**303-338-3220**
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**

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.

To receive this document in alternative formats (braille, large print, audiotapes, additional languages)	
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.

Para recibir este documento en español	
Llame al	**303-338-3800** o sin costo al **1-800-632-9700**
TTY	**711** Este número requiere equipo telefónico especial y es solamente para personas sordas, con dificultades auditivas o trastornos del habla.

TABLE OF CONTENTS

I. INTRODUCTION

Welcome!

Thank you for choosing Kaiser Permanente for your **Child Health Plan Plus (CHP+)** healthcare coverage. We are pleased to serve as your **CHP+** Health Maintenance Organization (HMO). We are a Colorado based, non-profit health plan. While you are enrolled in our plan, we are responsible for claims processing, referrals, authorizations, care management, and utilization review.

At Kaiser Permanente, our mission is to provide high-quality, affordable health care to improve the health of our members. We've always believed in putting you and your health first.

This booklet is called an Evidence of Coverage (EOC) and it explains the Services that are covered for you by Kaiser Permanente. Please read it carefully and store it in a safe place for your future reference.

Here is some information to help you as you read your EOC:

- Kaiser Permanente is sometimes called "we", "us", "our", and the "Health Plan".
- When we use the terms "you" and "your" we are referring to the children and pregnant women enrolled in **CHP+**.
- Enrolled persons are also sometimes called "Members" in this booklet.
- A provider that is not part of our Health Plan is sometimes called "out-of-Plan."
- Some capitalized terms in this EOC have special meaning and are terms you should know. These words may be explained in the section they are used or in the "Definitions" section.
- If you need help with this EOC, please call **Member Services**.

We will mail you a written notice of any important change to this EOC at least 30 days before the change takes effect. This includes changes to benefits and Services offered to you.

If you stay enrolled in **CHP+**, you will receive a postcard each year that tells you how to get a printed copy of the EOC. You may also view the EOC on **kp.org**.

You may ask for a copy of the EOC from **Member Services** at any time. They will send it to you within five (5) business days.

We can send you a copy in braille, large print, or in other languages at no cost to you.

Tenemos este libro disponible español. Si necesita información en español, llámenos al **303-338-3800** o **1-800-632-9700**.

II. HOW TO USE THIS BOOKLET

It is important to become familiar with your coverage so that you can take full advantage of the benefits we offer to people enrolled in **CHP+**. This EOC has the following sections:

A. Schedule of Benefits (Who Pays What)
B. Enrollment and Beginning of Coverage
C. Enrollment Fees
D. Annual Out-of-Pocket Maximums
E. Termination of Enrollment
F. How to Access Your Services and Get Approval of Benefits

G. Benefits (What is Covered)
H. Exclusions and Limitations (What is Not Covered)
I. Appeals and External Review
J. Member Satisfaction and Grievances Procedures
K. General Policy Provisions
L. Member Rights and Responsibilities
M. Definitions
N. Member Grievance/Complaint Form

III. ENROLLMENT AND BEGINNING OF COVERAGE

CHP+ is public low cost health insurance provided by the Colorado Department of Health Care Policy & Financing (the Department). Health insurance covers your costs for check-ups or if you get sick. To get **CHP+** coverage, you must follow the **CHP+** enrollment process. This process details who is eligible and what enrollment forms are required. To learn more about this process, please visit *Colorado.gov/hcpf/child-health-plan-plus*.

Once accepted into **CHP+**, you will receive a notice from the Department telling you when your coverage starts. The Department will also notify us of your enrollment on or before the 21st of the month. Coverage with our Health Plan will start the first of the next month. The expiration date of the health care benefits is printed on the **CHP+** Identification (ID) card.

Enrollment in this Health Plan is voluntary. You or the Department may end your enrollment with the Health Plan as described under "Termination of Enrollment."

You have the right to select your HMO for the **CHP+** program and can change your enrollment within the first 90 days of your enrollment and re-enrollment periods.

- If you would like to change your HMO, please contact the county department of human/social services in the county where you live or call the state enrollment broker at **1-888-367-6557**, Monday through Friday, 8 a.m. to 5 p.m.
- If you have questions about any of the information you have received from **CHP+** or about eligibility, please contact the county department of human/social services in the county where you live or call **CHP+** at **1-800-359-1991** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m. Or, visit *Colorado.gov/hcpf/child-health-plan-plus*.

Protect Yourself from Fraud!
We investigate all charges of fraud, waste, or abuse. If you suspect fraud, waste, or abuse, please call **Member Services**.

Here are some examples of possible fraud, waste, or abuse:
- Someone uses your CHP+ ID card to get services.
- Someone uses false information to mislead you into joining a Kaiser Permanente plan.
- Someone bills us for services you never got.
- Someone bills us for services that is different from the services you got.

IV. ENROLLMENT FEE

Some families enrolled in **CHP+** pay an annual enrollment fee. The amount of the fee is determined by the Department and is based on family size and income. At the end of one year, you will need to complete a new application with new required documents to continue your coverage. Any questions you may have about enrollment or fees should be directed to the Department at **1-800-359-1991**. All fee payments should be mailed to: **Department of Health Care Policy & Financing, P.O. Box 17548, Denver, CO 80217**.

V. ANNUAL OUT-OF-POCKET MAXIMUMS

There is a limit to the total amount of fees and Copayments you must pay in a year for certain Services covered under this EOC. This is called an Out-of-Pocket Maximum.

Your Out-of-Pocket Maximum will be no more than five percent (5%) of your family's gross annual income for the sum of all your family's Copayments.

CHP+ Members who are American Indians or Alaska Natives are exempt from Copayments and annual enrollment fees. Pregnant women are exempt from annual enrollment fees.

You are required to keep track of the money you spend on your health care Services. Save your Copayment receipts. Notify the Department if your receipts exceed your Out-of-Pocket Maximum. Call **CHP+** customer service at 1-800-359-1991. They will then ask you to mail in your saved receipts. The **CHP+** mailing address is: **Department of Health Care Policy & Financing, P.O. Box 17548, Denver, CO 80217**.

VI. TERMINATION OF ENROLLMENT

A. How Your Enrollment May Be Terminated

Your enrollment may be terminated at the end of any month by giving you 30 days' written notice. If you are an inpatient in a hospital or institution, your coverage will continue until your date of discharge. This does not apply if the Department terminates your enrollment due to fraud or abuse.

1. Termination for Cause

   The Department may terminate your enrollment by sending written notice to you at least 30 days before the termination date if any of the following happen:

   a. You are disruptive, unruly, or abusive to the Health Plan or a Plan Provider and make it hard for them to provide normal Services to you or other Members; or

   b. You give wrong or incomplete information to us on purpose; or

   c. You do not inform us of an important change in family status. This includes Medicare and Medicaid eligibility, that may affect your eligibility or benefits; or

   d. You knowingly:

   - misrepresent enrollment status; or
   - present an invalid prescription; or
   - misuse or allow the misuse of a Health Plan ID card; or
   - commit any other type of fraud with regard to your enrollment.

   All rights to benefits stop on the date of the termination. You will not be allowed to re-enroll in the Health Plan. You will be billed as a non-Member for any Services received after the date of termination if you are no longer eligible for **CHP+** coverage. You may file a grievance about your termination by contacting **Member Services** or you may contact the **Department of Health Care Policy & Financing, CHP+ Health Plan Manager, 1570 Grant Street, Denver, CO 80203. Their telephone number is 303-866-3586.**

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

B. How You May Terminate Your Enrollment

You may terminate your enrollment by sending a completed Change Form to the Department 30 days before the effective date of termination at the following address: **Department of Health Care Policy & Financing, P.O. Box 17548, Denver CO 80217**.

Refunds and Payments:

If terminated, any refund owed to you for claims or Services while you were a Member will be paid to you. Any Copayment you owe us will be taken out of any refund we make to you. We will make any payment due to you within 30 days after your enrollment ends.

C. Right to Benefits Ends

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

D. Moving Outside the Service Area

You must tell us right away if you move outside the Service Area. If you move out of our Service Area, your coverage will end. You must also notify **CHP+** of a change of address.

VII. HOW TO ACCESS YOUR SERVICES AND GET APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must get all covered Services from Plan Providers inside our Service Area. The only exceptions are:

- Emergency Services (in the "Benefits (What is Covered)" section).
- Urgent Care Services (in the "Benefits (What is Covered)" section).
- Family Planning Services (in the "Benefits (What is Covered)" section).
- When you receive a referral (see "Getting a Referral" in this section).

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role. A PCP is a Plan Provider that you choose to supervise, coordinate, and provide health care Services. They also help with hospital stays and referrals to specialists.

1. Choosing Your Primary Care Provider

   You can choose a PCP from family medicine, pediatrics, or internal medicine. You may also get a second medical opinion from a Plan Physician if you request it. Please refer to the "Second Opinions" section below.

   You can choose your PCP from our provider directory. You can get a list of Plan Providers and their biographies by visiting our website. Go to **kp.org**, click on "Find doctors and locations." You can also get a copy of the directory by calling **Member Services**. For help selecting a PCP, call **Appointments and Medical Advice**. This team will help you choose a Plan Provider accepting new patients, based on your health care needs. They can also help you find a Plan Provider that speaks non-English languages.

2. Changing Your Primary Care Provider

   You may change your PCP at any time. Please call **Appointments and Medical Advice** to make the change. You may also change your PCP when visiting a Plan Facility.

B. Getting a Referral

1. Referrals

   Plan Providers offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Plan Provider decides that you need covered Services not available from us, he or she will refer you to a Plan Provider or non-Plan Provider. The referral may be inside or outside our Service Area.

   You must have a written referral from a Plan Provider to get covered Services from providers other than a Plan Provider. The referral needs to be approved by the Health Plan. Not all referrals are approved. If you do not get a written approval, you may need to pay for the services you receive. Copayments for referral covered Services are the same as those for covered Services provided by a

Plan Provider. You cannot receive a referral for Services not covered by this plan.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved before the visit. The non-Plan Provider is only approved to give you the care stated on the referral. We will not pay for any other care unless it is approved in advance by the Health Plan.

2. Specialty Self-Referrals
You do not need a referral for the following services. These are called specialty self-referrals.

   a. Obstetrical or gynecological care for female members from a Plan Provider who specializes in obstetrics or gynecology.

   b. Routine office visits to specialty care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department.

   You are required to get a written referral for laboratory or radiology Services and for specialty procedures such as a CT scan, MRI, or surgery.

   A written and approved referral is also needed for specialty care visits to a non-Plan Provider. See "Referrals" above.

3. Second Opinions
You may get a second opinion from a Plan Physician about any proposed covered Service. A second opinion is when you visit another Plan Physician and have them review the first Plan Physician's plan for treatment. To get a second opinion, you must request it and pay the Copayment that applies to the visit.

   A written and approved referral is also needed for a second opinion from a non-Plan Provider. See "Referrals" above.

C. Utilization Management

Utilization Management is used to decide if you are getting the right Services at the right time. Utilization criteria are applied along with medical expert opinions, when necessary, in making approval decisions. When an approval for Services is requested, the Health Plan's Quality and Resource Management Program has adopted the following utilization management principles:

- Utilization management decisions (pre-service, concurrent, and post service) are based on appropriateness of care, specific plan benefits, and current eligibility.
- No practitioner or other staff member reviewing resource utilization is rewarded for issuing denials of coverage or service.
- No financial incentives exist that encourage denials of coverage or service that result in decreased use of services.

If you have Utilization Management questions, please call 1-877-895-2705 (TTY: 711), Monday through Friday, 8:30 a.m. to 4:30 p.m. Staff will provide a telephone interpreter to assist with utilization management issues to individuals who speak limited or no English free of charge.

If you call after normal business hours, your message will be forwarded to our utilization management staff. Your call will be returned the next business day. To get a copy of Utilization Management principles, please call the number provided above.

We do not make covered service determinations or utilization review determinations based on the grounds of moral or religious beliefs. If you are refused a covered service based on moral or religious beliefs, please contact us. We will assist you in finding a different provider who will provide the covered services you need.

There are three (3) types of requests made to the Health Plan's Quality and Resource Management Program. They are Pre-service, Concurrent, and Post Service requests.

1. Pre-service and Concurrent Request

   A request for Services you have not received yet is called a Pre-Service request. This includes your Plan Provider's referral to an outside provider for covered Services.

   A request to continue to pay for ongoing Services you are receiving but are scheduled to end or be reduced is called a Concurrent Care request.

   If a request for Pre-service or Concurrent Services is made on your behalf, you need to wait for the Health Plan to make a decision based on utilization management principles. The Health Plan will mail you a notice telling you the decision.

   a. For a Pre-Service request, this may take ten (10) calendar days from our receipt of the request. We can extend the review time up to fourteen (14) calendar days if you ask us to. We can also extend the time if more information is needed and the delay is in your best interest.

   b. For Concurrent Care requests, we will mail you a response ten (10) calendar days before the end or reduction of Service.

2. Post Service Request

   A request for Services you have already received is called a Post Services request. This included requests for out-of-Plan Emergency Services and non-covered Services.

   The Health Plan may take 30 calendar days to make a decision on a Post Service request. If we have all the information we need, we will give you a written notice of our decision to pay, deny or limit the payment on the request. If we deny or limit the payment of the request, we will tell you how you can appeal the decision.

D. Request for Services

A request for Services or a referral to an outside provider may be made for care you urgently need. This is called a "Request for Urgently Needed Services." Your Plan Provider will tell us if they believe the request is urgent. The Health Plan may determine if the request is urgent on its own. A request is usually urgent when:

1. A delay could seriously risk your life, health, or ability to regain maximum function;
2. A delay could subject you to severe pain, in the opinion of a Plan Physician with knowledge of your medical condition;
3. Your Plan Provider asks that the request be treated as urgent.

If we decide the request is urgent, we will give you notice as fast as your health condition requires. The notice may be written or oral. This will be no later than seventy-two (72) hours after receipt of the request. We may extend this timeframe to 14 calendar days if:

1. You or your Plan Provider request an extension; or
2. We decide that more information is needed and an extension is in your best interest.

If we extend the timeframe, we will give you written notice of this within three (3) working days. You may file a grievance if you do not agree with the extension. Please see the "Member Satisfaction and Grievances Procedures" section for more information.

After we review the request, we may need more information. We will notify you of our decision two (2) working days after we receive the new information. If you do not send us the information we request, we will send you our decision within two (2) working days after making the request.

E. Plan Facilities

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

We offer health care at Plan Medical Offices at convenient locations in our Service Area. At most of our Plan Facilities, you can receive all the covered Services you need. This includes specialized care. You are welcome to use the Plan Facilities that will be most convenient for you.

Plan Facilities are listed in our provider directory, which we update monthly. 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, **kp.org**, by clicking on "Locate our Services" then "Find doctors and locations."

F. Getting the Care You Need

If you think you have an Emergency, call 911 or go to the nearest emergency room.

We cover Emergency care 24 HOURS A DAY, 7 DAYS A WEEK anywhere in the world. You do not need Prior Authorization to receive Emergency Services.

When you are inside our Service Area, we only pay for Urgent Care Services received at a Plan Provider. If you receive Urgent Care Services at a non-Plan Provider inside our Service Area, you will need to pay for the medical treatment you receive. If you are outside the Service Area, we will pay for the Urgent Care Services received from a non-Plan Provider.

For coverage information about Emergency and Urgent Care Services, please refer to the "Emergency Services and Urgent Care" in the "Benefits (What is Covered)" section.

Appointment Scheduling Guidelines

The following scheduling guidelines apply by service type:

Service Type	Scheduling Guideline
Urgently needed services	Within twenty-four (24) hours of the time your primary care provider is notified of your need for services.
Non-emergent, non-urgent medical problems	Within thirty (30) calendar days of the request for service. Note: This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days.
Non-urgent, symptomatic care	Within seven (7) calendar days of the request for service.
Routine well care physical examinations/behavioral health screening	Within thirty (30) calendar days of the request for service.
Follow-up appointment	Within seven (7) calendar days after discharge from a hospital.
Diagnosis and treatment of a non-emergent, non-urgent mental health condition	Within seven (7) calendar days of the request for service.

Diagnosis and treatment of a Non-emergent, non-urgent substance abuse condition	Within seven (7) calendar days of the request for service.
Emergency behavioral health care	Within fifteen (15) minutes after the initial contact by phone, including TTY accessibility; in person, within one (1) hour of contact in urban and suburban areas and within two (2) hours of contact in rural and frontier areas.

Note: If we make a change to a Plan Medical Office in the Service Area, we will tell you of the change by mail.

G. Continuity of Care Provision

We will provide Continuity of Care services for newly enrolled members. For the purpose of this EOC, Continuity of Care means that we will cover Medically Necessary transitional care and treatment received from your prior health care providers (non-Plan Providers) if the Services are otherwise covered under this EOC. This includes members with special health care needs. Special health care needs may include, but are not limited to: mental health; high risk health problems; functional problems, language or comprehension barriers; and other complex health problems. Talk to your PCP about care or treatment you are receiving from a non-Plan Provider and the need for these Services to be transitioned to Kaiser Permanente.

Transition Period

The transition period for Continuity of Care is a limited period of time that will ensure you receive Medically Necessary care that is suited to your medical condition. In most cases, this will not exceed a period of 60 calendar days. For members with special health care needs, the transition period is:

a. 60 calendar days for covered Services provided by non-Plan Providers.

b. 75 calendar days for covered Services provided by ancillary or non-network Providers.

Note: Members in their second or third trimester of pregnancy may continue to see their non-Plan Provider until the completion of postpartum care.

You must transition your care to a Medical Group physician by the end of the authorized time period. Failure to transition care to a Medical Group physician by the end of this time period will result in non-payment by the Health Plan of any outstanding and future claims by the non-Plan Provider.

H. Rescheduling of Services

We may reschedule non-urgent appointments if you owe us money for Services you have received in the past. When you pay the amount you owe or set up a payment plan, you will be able to schedule these appointments again.

I. Using Your Health Plan Identification Card

Each Member gets a Health Plan Identification (ID) card. Your card will have a Health Record Number on it. You will be asked for your Health Record Number when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and enrollment information. You should always have the same Health Record Number. Please call **Member Services** if we ever make a mistake and issue you more than one Health Record Number. If you need to replace your Health Plan ID card, please call **Member Services**.

Your Health Plan ID card is for identification only. To receive 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 and claims for any Services from non-Plan providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your enrollment. Please refer to the "Termination of Enrollment" section for more information.

When you receive Services, you will need to show a photo ID card and your Health Plan ID card. This helps us protect your identity and to better protect your coverage and medical information from fraud. If you think you are a victim of fraud, please call **Member Services**.

VIII. BENEFITS (WHAT IS COVERED)

This section describes the Services you may receive as a **CHP+** Member. We do not cover Services listed as an exclusion in this booklet. Your benefits are subject to the limitations and exceptions as noted throughout this EOC. Services are covered only if all the following conditions are met:

- The Services are Medically Necessary as defined in this EOC; and
- The Services are provided, prescribed, authorized or directed by a Plan Physician. This does not apply as discussed in the following sections of this EOC:
  - "Emergency Services"; and
  - "Out-of-Plan Urgent Care"; and
- You receive the Services from Plan Providers inside our Service Area. This does not apply as discussed in the following sections of this EOC:
  - "Getting a Referral" and "Specialty Self-Referrals"; and
  - "Emergency Services"; and
  - "Urgent Care Services When You Are Outside the Service Area."

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

Note: Copayments may apply to the benefits listed below. To see how much a benefit or Service will cost you, please go to the "Schedule of Benefits (Who Pays What)."

A. Outpatient Care

1. Outpatient Care for Preventive Care, Diagnosis, and Treatment
   We cover the following outpatient care for preventive care, diagnosis, and treatment. This includes professional medical Services of physicians and other health care professionals: (i) in the physician's office; (ii) during medical office consultations; (iii) in a Skilled Nursing Facility; or (iv) at home. Your outpatient care includes:
   a. Primary care visits: Services from family medicine, internal medicine and pediatrics.
   b. Specialty care visits: Services from providers that are not primary care, as defined above.
   c. Routine prenatal and postpartum visits (No charge). The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment for all other Services received during a prenatal visit.
   d. Allergy testing and treatment.
   e. Fluoride Varnish treatment.
   f. Consultations with clinical pharmacists.
   g. Drugs, dressings and casts administered during a covered visit (No charge).
   h. Outpatient surgery.
   i. Blood, blood products and their administration.

j. Second opinion.

k. House calls.

l. Medical social Services.

m. Preventive care Services (see "Preventive Care Services" in this "Benefits (What is Covered)" section for more details).

n. Virtual care Services.

2. Outpatient Care Exclusions

These Services are not covered by this plan:

Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

We cover inpatient Services in a Plan Hospital, when the Services are typically provided by acute care general hospitals in our Service Area. The following Services are covered:

a. Room and board in a semi-private room (with two or more beds). A private room or private duty nursing care is provided if a Plan Physician determines it is Medically Necessary.

b. Intensive care and related hospital Services.

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

d. General nursing care.

e. Obstetrical care and delivery. This includes cesarean section.

i. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning.
ii. Your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. This may happen if you are discharged within 48 hours after delivery, or 96 hours if the delivery is by cesarean section.
iii. If your newborn stays in the hospital after your discharge, there will be Copayments for the Services they receive. You must pay the newborn's copayments.

f. Bariatric surgery is covered if you meet Medical Group criteria.

g. Meals and special diets.

h. Other hospital Services and supplies, such as:

i. Operating, recovery, maternity and other treatment room.
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

These Services are not covered by this plan:

a. Dental Services, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.

b. Cosmetic surgery related to bariatric surgery.

c. Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.

C. Ambulance Services

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

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

D. Dialysis Care

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

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

After the referral to a dialysis facility, we cover: equipment; training; and medical supplies required for home dialysis.

E. Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary is a list of prescription drugs that have been approved by our formulary committee for our Members. Our committee is made up of physicians and pharmacists. It is known as the Pharmacy and Therapeutics Committee. The committee selects prescription drugs for our drug formulary based on several factors. This includes safety and effectiveness, as determined from a review of medical literature and research. The committee meets on a regular basis 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**.

1. Coverage
   a. Outpatient Prescription Drugs
      This section tells you what drugs, supplies, and supplements are covered when you go to a Plan Pharmacy. You can find a facility with a Plan Pharmacy by visiting our website. Go to **kp.org**, click on "Locate our services" then "Find doctors & locations." You can also call **Member Services** for help.

      The following drugs are covered only when prescribed by: (i) a Plan Physician; or (ii) a physician to whom a Member has been referred by a Plan Physician; or (iii) a dentist (when prescribed for acute conditions), and when you get them at Plan Pharmacies:

      i. Insulin
      ii. Drugs for which a prescription is required by law.

      Prescribed covered drugs are provided in prescribed quantities at the Copayment shown on the "Schedule of Benefits (Who Pays What)." If your prescription drug Copayment shown on the "Schedule of Benefits (Who Pays What)" is more than the cost for your prescribed medication,

then you pay the cost of the medication instead of the Copayment.

Plan Pharmacies may substitute a generic equivalent for a brand name drug unless not allowed by the Plan Physician. If you request a brand name drug when a generic equivalent drug is the preferred product, you must pay any difference in price between the preferred generic equivalent drug prescribed by the Plan Physician and the requested brand name drug. If the brand name drug is prescribed due to Medical Necessity, you pay only the brand name Copayment.

Generic drugs available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) the Health Plan subscribes to are provided at the brand name Copayment. The amount covered will be the lesser of the quantity prescribed or the Day Supply Limit. A Day Supply Limit is the amount of a drug that can be dispensed at a time. For example, you may receive a 30 day supply.

The amount covered cannot exceed the Day Supply Limit for each maintenance drug or up to the Day Supply Limit for each non-maintenance drug. Certain drugs have a higher potential for waste and diversion. Those drugs will be provided for up to a 30 day supply, at the prescription drug Copayment. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any prescribed amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may establish quantity limits for specific prescription drugs.

b. Administered Drugs

We cover the following administered drugs as part of your Hospital Inpatient Care and Skilled Nursing Facility benefit. They are covered without charge if: the following drugs are: (i) administered in a Plan Medical Office; or (ii) during home visits if administration or observation by medical personnel is required.

- Drugs and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

c. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail order prescription service with no charge for postage and handling. You may get refills of maintenance drugs prescribed by Plan Physicians up to the mail order day supply, at the related Copayment. Maintenance drugs are defined by the Health Plan. Certain drugs have a higher potential for waste and diversion. Those drugs are not available by mail order service. For information about our mail order prescription service and drugs not available by mail order, please contact **Member Services**.

d. Food Supplements

The following are provided under your Hospital Inpatient Care benefit: prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism; elemental enteral nutrition and parenteral nutrition; formulas for gastrostomy tubes; and formulas for children with gastrointestinal disorders, malabsorption syndromes or a condition that affects growth pattern or normal absorption or nutrition. Such products are covered at the related Copayment for self-administered use. Food products for enteral feedings are not covered.

e. Prescribed Supplies and Accessories

Prescribed supplies will be provided when you get them at a Plan Pharmacy or from sources

approved by the Health Plan. Such items include, but may not be limited to: home glucose monitoring supplies; disposable syringes for the administration of insulin; glucose test strips; acetone test tablets; and nitrate screening test strips for pediatric patient home use. For more information, see the "Schedule of Benefits (Who Pays What)."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary, for the treatment of substance use disorder.
   c. With the exception of substance use disorder drugs, we may apply step therapy to certain drugs.
   d. Compound medications are covered as long as they are on the formulary.
3. Drugs, Supplies, and Supplements Exclusions
   The following are not covered by this plan:
   a. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings and ace-type bandages.
   b. Drugs and injections for treatment of sexual dysfunction.
   c. Drugs or injections for the treatment of infertility.
   d. Prescribed drugs necessary for Services excluded under the **CHP+** contract.
   e. Drugs to shorten the length of the common cold.
   f. Drugs to enhance athletic performance.
   g. Drugs for the treatment of weight control.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Individual drugs and/or drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   j. Unless approved by the Health Plan, drugs;
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
   k. Any packaging of prescription drugs except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.

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

We cover DME, prosthetics and orthotics listed on our DME formulary.

- They need to be prescribed by a Plan Physician
- They require Prior Authorization from the Health Plan.
- You need to get them from sources approved by the Health Plan.

The Health Plan determines whether the items should be purchased or rented. Replacements needed due to normal wear are covered if the DME is still medically needed. Replacements will not be covered if

they were: (i) damaged due to neglect or abuse; or (ii) lost. See the "Schedule of Benefits (Who Pays What)" for more information.

Needed fittings, repairs and adjustments, other than those needed due to misuse, are covered. The Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no charge. You will be charged as a non-Member for any DME, prosthetics, orthotics and/or needed repairs and adjustments after the annual maximum benefit is paid by the Health Plan each year.

Limitations: Coverage is limited to: (1) A standard item of DME, orthotic device or prosthetic device that meets a Member's medical needs, and (2) The annual maximum benefit paid by the Health Plan as shown on the "Schedule of Benefits (Who Pays What)."

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME that is Medically Necessary and listed on our DME formulary.
      ii. DME is Medically Necessary equipment that can be used in the home. It is able to withstand repeated use, only of use to a person with an illness or injury. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      iii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when you get them from sources named by the Health Plan. The annual maximum benefit does not apply to insulin pumps or insulin pump supplies.
      iv. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor named by the Health Plan.
      v. When use is no longer prescribed by a Plan Physician, DME must be returned to the Health Plan or its designee. If the equipment is not returned, you must pay the Health Plan or its designee the fair market price, established by the Health Plan, for the equipment.
   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by the Health Plan.
   c. Durable Medical Equipment Exclusions
      The following are not covered by this plan:
      i. Electronic monitors of bodily functions, except infant apnea monitors.
      ii. Devices to perform medical testing of body fluids, excretions or substances. Note: Nitrate urine test strips for home use for pediatric patients are covered and not excluded.
      iii. Non-medical items such as sauna baths or elevator features.
      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 equipment.
      viii. Repair, adjustments or replacements as a result of misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those devices that replace all or any part of a body organ or extremity. Coverage of prosthetic devices includes:

      i. Internally implanted devices for functional purposes. For example, pacemakers and hip joints. (The annual maximum benefit does not apply.)
      ii. Prosthetic devices for Members who have had a mastectomy. The Medical Group lets you know where to get the devices. Replacement will be made when a device is no longer functional. Custom made prostheses will be provided when needed. (The annual maximum benefit does not apply.)
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate. These need to be prescribed by a Plan Physician and you must get them from sources approved by the Health Plan. (The annual benefit maximum benefit does not apply.)
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician as Medically Necessary. You must get them from sources approved by the Health Plan. Payment by the Health Plan will be based on this EOC. (The annual maximum benefit does not apply.)

   b. Prosthetic Device Exclusions
      The following are not covered by this plan:

      i. Dental prostheses, except for those Medically Necessary to treat cleft lip and cleft palate, as described above.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements. Spare devices or alternate use devices not provided.
      iv. Replacement of lost prosthetic devices.
      v. Repairs, adjustments or replacements needed due to misuse.

3. Orthotic Devices
   a. Coverage
      Orthotic devices are rigid or semi-rigid external devices (other than casts) that: (i) are required to support or correct a defective form or function of an inoperative or malfunctioning body part; or (ii) restrict motion in a diseased or injured part of the body.

   b. Orthotic Device Exclusions
      The following are not covered:

      i. Corrective shoes and orthotic devices for podiatric use and arch supports. This exclusion does not include: diabetic or therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances. Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician. If a Member is covered for these Services under a dental insurance policy or contract, they are not covered by us.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for replacements. Spare devices or alternate use devices are not covered.
      v. Replacement of lost orthotic devices.
      vi. Repairs, adjustments or replacements needed due to misuse.

G. Emergency Services and Urgent Care Services

1. Emergency Services

If you think you have an Emergency, call 911 or go to the nearest hospital emergency room.

Emergency Services are available at all times – 24 HOURS A DAY, 7 DAYS A WEEK. You do not need Prior Authorization or a referral. You have the right to use any hospital or other setting for emergency care.

We cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world. For information about Emergency benefits away from home, please call **Member Services.**

a. After Your Emergency is Stabilized (Post-Stabilization)

After your Emergency is Stabilized (whether inside or outside our Service Area) we cover Services you may need when approved by a Plan Provider. These Services are called post-Stabilization Services. These are Services that an Emergency Services provider says are needed before you can go home or be moved to a Plan Facility to continue needed care.

Once you are Stabilized, ongoing care is no longer considered an Emergency Medical Condition. At this time we will decide whether you should be transferred to a Plan Facility for ongoing care. Ongoing Services out-of-Plan will need to be preauthorized by us to be covered. When approved by us, we will help transfer you to a Plan Facility inside the Service Area.

Non-Emergency Services are not covered after we have approved your transfer to a Plan Facility. You will be responsible for payment for any post-Stabilization treatment if you decide to stay at the non-Plan Facility.

b. Notice to the Health Plan of Receipt of Emergency Services

We request if you are admitted to a non-Plan Hospital, non-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf tell us within 24 hours, or as soon as possible. Please call **Member Services**.

Please note: If you receive Services unrelated to the Emergency, you may be charged a separate Copayment.

c. Emergency Services Exclusions

These Services are not covered by this plan:

i. Routine care that is **not** treatment for an Emergency Medical Condition provided in an emergency medical facility.

ii. Follow-up care that is not preauthorized. Any Services you need after you are Stabilized should be provided by a Plan Provider, not in an emergency medical facility.

2. Urgent Care Services

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.

If you have an illness or injury and you are not sure what kind of care you need, our **Advice Nurses** can help. They are available 24 hours a day, 7 days a week. 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. This may include making an appointment for you, or referring you to an Urgent Care Services Plan Facility or an emergency room.

a. Urgent Care Services When You Are In the Service Area

If you are inside the Service Area and you need Urgent Care Services, you do not need to get

Prior Authorization if you go to a Plan Provider. If you go to a non-Plan Provider without Prior Authorization, we will not pay for the Urgent Care Services (or any related Services) that you receive. For information regarding the designated Urgent Care Services Plan Facilities, please call **Member Services** or go to **kp.org**.

Urgent Care Services are covered at Plan Facilities inside our Service Area. You will pay an office visit Copayment, as defined in the "Schedule of Benefits (Who Pays What)." If you receive Urgent Care Services at a non-Plan Provider, you will have to pay for your care.

b. Urgent Care Services When You Are Outside the Service Area
If you are outside the Service Area and you need Urgent Care Services, you may visit a non-Plan Provider without getting Prior Authorization. You do not need to call **Member Services** before you get Urgent Care Services.

H. Family Planning Services

This section tells you about covered services and exclusions for family planning services. Family planning Services are Medically Necessary services that prevent or delay pregnancy. These services do not require prior authorization or referral for any provider regardless of whether they are in-network or not. This could be a PCP or OB/GYN.

1. Coverage
We cover the following family planning services:
   a. Prescription birth control.
   b. Depo-Provera for birth control purposes.
   c. Fitting of a diaphragm or cervical cap.
   d. Surgical implantation and removal of an Implantable Contraceptive Device.
   e. Fitting, inserting, or removing Intrauterine Device (IUD).
   f. IUDs, diaphragms, Implantable Contraceptive Devices, and cervical caps given in a provider's office.
2. Family Planning Services Exclusions
These Services are not covered by this plan:
   a. Surgical sterilization (for example, tubal ligation or vasectomy) and related services.
   b. Reversals of sterilization procedures.
   c. Some over-the-counter contraceptive products such as spermicide.
   d. Preconception, paternity, or court-ordered genetic counseling and testing (for example, tests to determine the sex or physical characteristics of an unborn child).
   e. Choosing to end (elective termination) a pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

I. 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.

J. Hearing Services

1. Coverage
We cover hearing exams and tests for you through age 18 to determine the need for hearing correction. If you have a verified hearing loss, coverage includes:
   a. Initial hearing aids and replacement hearing aids not more frequently than every 5 years;

b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet your needs; and

c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided based on accepted professional standards.

K. Home Health Care

1. Coverage

We cover skilled nursing care, home health aide Services and medical social Services only:

a. on a Part-Time Care or Intermittent Care basis, as provided on the "Schedule of Benefits (Who Pays What);" and

b. within our Service Area; and

c. if you are confined to your home; and

d. if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Part-Time Care or Intermittent Care means skilled nursing and home health aide Services that occur from time to time and on a part time basis. These Services are available when they are Medically Necessary:

- up to 28 hours per week combined over any number of days per week; and
- less than eight (8) hours per day.

Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by the Health Plan on a case-by-case basis.

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

2. Home Health Care Exclusions

These Services are not covered by this plan:

a. Custodial (non-medical) care.

b. Homemaker Services.

c. Care that the Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility.

3. Special Services Program

If you are diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible to receive home health visits through the Special Services Program ("Program"). These visits are without charge until you elect hospice care coverage. Coverage of hospice care is described below.

This Program gives you and your family time to become more familiar with hospice Services and to decide what is best for you. When you have the option to participate in this Program, it can help you bridge the gap between your diagnosis and preparing for the end of life.

The difference between this Program and regular visiting nurse visits is that: (1) you may or may not be homebound or have skilled nursing care needs; or (2) you may only require spiritual or emotional care. The Services available through this Program are provided by professionals with specific training in end-of-life issues.

L. Hospice Care

We cover hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness with a life expectancy of six (6) months or less, you can choose hospice care instead of traditional Services provided for the illness. You pay the Copayment, if any, listed on the "Schedule of Benefits (Who Pays What)."

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 hospice care Services and other benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved in writing by the Medical Group:

a. Physician care.

b. Nursing care.

c. Physical, respiratory, occupational or speech therapy.

d. Medical social Services.

e. Home health aide and homemaker Services.

f. Medical supplies, drugs, biologicals and appliances.

g. Physician Services.

h. Palliative drugs based on our drug formulary guidelines.

i. Short-term inpatient care, including respite care and care for pain control and acute and chronic pain management.

j. Counseling and bereavement Services.

k. Services of volunteers.

M. Mental Health Services

Medical Services for mental health treatment are covered in the same way as for other medical conditions.

1. Inpatient Services

   We cover mental health Services as shown below.

   a. Medical and Hospital Services

      We cover psychiatric hospitalization in a facility designated by the Medical Group or Health Plan. You pay the Copayment, if any, shown on the "Schedule of Benefits (Who Pays What)." Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed while you are a registered bed patient:

      i. Room and board.
      ii. Psychiatric nursing care.
      iii. Group therapy.
      iv. Electroconvulsive therapy.
      v. Occupational therapy.
      vi. Drug therapy and medical supplies.

   b. Residential Care

      We cover residential treatment services in a Plan Hospital based program at the Copayment shown on the "Schedule of Benefits (Who Pays What)," if you are admitted directly from an inpatient hospital admission into a partial hospitalization treatment program. If your inpatient

hospital stay does not come right before admission into a residential treatment program, a separate inpatient hospital Copayment may apply.

2. Outpatient Services
We cover: diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling at the Copayment shown on the "Schedule of Benefits (Who Pays What)."

Partial hospitalization treatment may be used in place of inpatient days, if approved by a Health Plan Provider.

In addition, visits for the following are covered:

a. Monitoring of drug therapy.

b. Psychological testing as part of diagnostic evaluation.

3. Mental Health Services Exclusions
These Services are not covered by this plan:

a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Medical Group physician determines such evaluations are Medically Necessary.

b. Mental health Services on court order, to be used in a court proceeding, or as a condition of parole or probation, unless a Medical Group physician determines such care is Medically Necessary.

c. Marital and social counseling.

d. Services which are custodial in nature.

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

1. Coverage

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

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

We cover children from birth up to the child's third (3rd) birthday: (1) if diagnosed with significant delays in development; or (2) have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law. See the "Schedule of Benefits (Who Pays What)" for additional benefit information.

c. Multidisciplinary Rehabilitation
We cover treatment for up to 30 days per year while you are an inpatient in an organized, multidisciplinary rehabilitation Services program in a designated facility or Skilled Nursing Facility.

d. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions in this EOC apply, except that we cover Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for children from birth up to the child's fifth (5th)

birthday. We cover 30 therapy visits per year for physical, occupational, and speech therapy combined. Such visits are distributed as Medically Necessary throughout the year without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity.

2. Limitations
   a. Speech therapy is limited to treatment for speech impairments due to injury or illness of specific organic origin. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long-term and chronic in nature.
   b. Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.
   c. Speech therapy visits for treatment of cleft lip or cleft palate are unlimited if Medically Necessary.
3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   These Services are not covered by this plan:
   a. Cardiac rehabilitation programs.
   b. Maintenance therapy or care after the Member has reached rehabilitative potential.
   c. Membership at health spas or fitness centers.
   d. Any therapeutic exercise equipment prescribed for home use.
   e. Therapies for learning disorders, developmental delays, stuttering, voice disorders, or rhythm disorders.
   f. Long-term rehabilitation.
   g. 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.

O. Preventive Care Services

Preventive care Services are Services to keep you healthy or to prevent illness. These Services are not intended to treat an existing illness, injury or condition. Please refer to the "Schedule of Benefits (Who Pays What)" for Copayments that may apply to preventive care Services. Should you receive Services for an existing illness, injury or condition **during** a preventive care examination, you may be charged an additional office visit Copayment.

Preventive care Services include the following:

1. Health maintenance visits.
2. Well child and well baby visits.
3. Behavioral health screening.
4. Immunization visits.
5. Routine screenings such as blood cholesterol, colorectal cancer screening and Pap smears.
6. Screening mammograms and clinical breast exams.
7. Prostate screening.

P. Reconstructive Surgery

See "Outpatient Care" and "Hospital Inpatient Care" for your copayment or coinsurance.

1. Coverage

   We cover reconstructive surgery when a Plan Physician determines it:

   a. will correct a significant disfigurement resulting from an injury or Medically Necessary surgery; or

   b. will treat a congenital defect, disease or anomaly in order to produce a major improvement in physical function; or

   c. is necessary to treat congenital hemangioma (known as port wine stains) on the face and neck.

   Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast. We also cover surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment of physical complications, including lymphedemas.

2. Reconstructive Surgery Exclusions

   These Services are not covered by this plan:

   Plastic surgery or other cosmetic Services and supplies intended primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

Q. Skilled Nursing Facility Care

1. Coverage

   We cover up to 30 days per year of skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization from the Health Plan is required. The skilled inpatient Services must be those generally provided by Skilled Nursing Facilities. A prior three (3) day stay in an acute care hospital is not required. We cover the following Services:

   a. Medical and biological supplies.

   b. Nursing care.

   c. Room and board.

   d. Medical social Services.

   e. Blood, blood products and their administration.

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

   Note: Drugs are covered, but not under this section. See "Drugs, Supplies, and Supplements."

   DME and prosthetics and orthotics are covered, but not under this section. See "Durable Medical Equipment and Prosthetics and Orthotics."

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

2. Skilled Nursing Facility Care Exclusion

   The following is not covered by this plan:

   Custodial Care, as defined in "Exclusions" under "Exclusions and Limitations (What is Not Covered)" below.

R. Substance Use Disorder Services

1. Inpatient Services

   a. Medical and Hospital Services

      We cover Services for the medical management of withdrawal symptoms. Medical Services for

alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body. See the "Schedule of Benefits (Who Pays What)."

b. Residential Rehabilitation Services
We cover inpatient services and partial hospitalization in a residential rehabilitation program approved by Kaiser Permanente for the treatment of alcoholism, drug abuse, or drug addiction. See the "Schedule of Benefits (Who Pays What)."

A Plan Physician supervises the decision about the need for residential rehabilitation services and the referral to such a facility or program.

2. Outpatient Services
We cover outpatient rehabilitative Services for treatment of alcohol and drug dependency when referred by a Plan Physician. See the "Schedule of Benefits (Who Pays What)."

We cover substance use disorder Services, whether they are voluntary or are court ordered as a result of contact with the criminal justice or juvenile justice system. We do not cover court ordered treatment that exceeds the scope of coverage under this plan. We cover substance use disorder Services when:

a. they are Medically Necessary; and

b. they are otherwise covered Services under this plan; and

c. supplied by a Plan Provider.

Partial hospitalization treatment may be used in place of inpatient days, if approved by a Health Plan Provider.

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

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

3. Substance Use Disorder Services Exclusion
The following is not covered by this plan:
Counseling for a patient who is not responsive to therapeutic management as determined by a Plan Physician.

S. Transplant Services

1. Coverage
Transplants are covered on a **limited** basis as follows:

a. Bone marrow transplants (autologous stem cell or allogenic stem cell) for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer and Wiskott-Aldrich syndrome.

b. Cornea.

c. Kidney.

d. Liver.

e. Heart.

f. Heart-lung.

g. Lung (single or double) for end stage pulmonary disease only.

h. Kidney and pancreas transplants at the same time.

i. Stem cell rescue and transplants of organs, tissue or bone marrow when all medical criteria developed by Medical Group are met.

2. Related Prescription Drugs
Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are covered at the outpatient prescription drug Copayment as shown in the "Drugs, Supplies, and Supplements" section.

3. Terms and Conditions:
   a. The Health Plan, Medical Group and Plan Physicians do not undertake: (i) to provide a donor or donor organ or bone marrow or cornea; or (ii) to assure the availability of a donor or donor organ or bone marrow or cornea; or (iii) the availability or capacity of referral transplant facilities approved by the Medical Group.

      Based on our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person the Medical Group or a Plan Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

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

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

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

4. Transplant Lifetime Maximum (LTM) Benefit
The Transplant LTM is the maximum benefit paid by the Health Plan for covered Transplant Services.

   We will pay the accumulated cost of Transplant Services you receive up to the Transplant LTM of $1,000,000 while you are enrolled under this plan.

   The following will not apply toward the Transplant LTM:

   a. The cost of transplant medications.

   b. Covered traveling and lodging expenses.

5. Bone Marrow Donor Search Maximum Benefit
The Bone Marrow Donor Search Maximum is the maximum benefit paid by the Health Plan for bone marrow donor searches.

   We will pay the cost of bone marrow donor searches up to $25,000 while you are enrolled under this plan.

6. Transplant Services Exclusions and Limitations
These Services are not covered or are limited by this plan:

   a. Non-human and artificial organs and their implantation.

   b. Bone marrow transplants associated with high dose chemotherapy for solid tissue tumors (except bone marrow transplants covered under this EOC).

c. Travel and lodging expenses.

For information specific to your case, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

T. Vision Services

1. Coverage

We cover routine eye exams and refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional examinations and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan optometrist prescribes them for a specific medical condition.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional charge when you get them at a Health Plan Medical Office.

When prescribed by a physician or an optometrist and you get them at a Health Plan Medical Office, you receive a credit, as shown in the "Vision Services and Optical" section of the "Schedule of Benefits (Who Pays What)" toward the purchase of one pair of: (a) regular lenses; or (b) frames; or (c) Medically Necessary contact lenses. Covered Services include the frame, mounting of lenses in the frames, and the first fitting and adjustment of the frame. The credit can only be used when you make your purchase.

2. Vision Services Exclusions

These items and Services are not covered by this plan:

a. Contact lenses not Medically Necessary.

b. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary.

c. 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.

d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures).

e. Orthoptic (eye training) therapy.

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

1. Coverage

a. Outpatient

We cover the following Services:

i. Diagnostic X-ray and laboratory tests, Services and materials, which includes, but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms and ultrasounds.
ii. Therapeutic X-ray Services and materials.
iii. X-ray Special Procedures such as MRI, CT, PET and nuclear medicine. **Note:** Members will be billed for each separate procedure performed. If more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined based on the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association.

b. Inpatient

During hospitalization, the following are covered at the Copayment shown on the "Schedule of Benefits (Who Pays What)": prescribed diagnostic X-ray and laboratory tests; Services and materials, including diagnostic and therapeutic X-rays and isotopes; electrocardiograms and

electroencephalograms.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
These Services are not covered by this plan:

   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.

IX. EXCLUSIONS AND LIMITATIONS (WHAT IS NOT COVERED)

A. Exclusions

The list of exclusions below explains services that are not covered by your plan. These are general exclusions that apply to all Services described in this EOC. Exclusions that apply only to a specific covered Service are listed in the description of that Service in the "Benefits (What is Covered)" section. You do have to pay for services that are not covered.

1. **Applied Behavioral Analysis (ABA) Therapy**
2. **Alternative Medical Services.** Acupuncture Services, naturopathy Services, massage therapy, chiropractic Services and Services of chiropractors.
3. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.
4. **Biofeedback Services and Services Related to Biofeedback.**
5. **Convalescent Care.**
6. **Cosmetic Services.** Services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function. Exception: Services covered under "Reconstructive Surgery" in the "Benefits (What is Covered)" section.
7. **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.
8. **Custodial Care.** Custodial care is (a) assistance with activities of daily living which include, but are not limited to, walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine; or (b) 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.
9. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment.

   This exclusion does not apply to:

   (a) Medically Necessary Services for the treatment of cleft lip or cleft palate for newborns when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract; or

   (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma; or

   (c) medical coverage for accidental injury to sound natural teeth, if treatment is performed by a

physician or legally licensed dentist, and treatment is begun within 72 hours after the accidental injury.

Unless otherwise specified herein, (a) and (b) must be received at a Plan Hospital, Plan Facility, or Skilled Nursing Facility.

10. **Directed Blood Donations.**

11. **Disposable Supplies.** Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits (What is Covered)" section.

12. **Domiciliary Care.** Care provided in a non-treatment institution, halfway house or school.

13. **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 his or her 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) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

14. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or government agency is required by law to provide, other than those **CHP+** Services covered by the Department under its **CHP+** program.

15. **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 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 concerning the safety; toxicity or efficacy of Services; or
        vi. has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by the 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 evaluated for its safety, toxicity or efficacy; or

viii. is a 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 necessary 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. Your medical records; and

ii. The written protocols or other documents under which the Service has been or will be provided; and

iii. Any consent documents you or your 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 your 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. The Health Plan consults the Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

16. **Genetic testing.** The Health Plan does not cover genetic testing unless determined to be Medically Necessary and meets Medical Group criteria.

17. **Hair Loss Treatments.** The Health Plan does not cover treatment for hair loss even if there is a prescription and a medical reason for the hair loss.

18. **Hypnosis.** The Health Plan does not cover Services related to hypnosis whether for medical or anesthesia purposes.

19. **Illegal Conduct.** The Health Plan does not cover any loss caused by attempting or committing a felony or engaging in an illegal occupation.

20. **Infant Formula.**

21. **Infertility Services.**

22. **Intermediate Care.** The Health Plan does not cover care in an intermediate care facility.

23. **Non-Medical Case Management.**

24. **Nutritional Therapy.**

25. **Personal Comfort and Convenience Items.**

26. **Private Duty Nursing Services.**

27. **Routine Foot Care Services.** The Health Plan does not cover routine foot care Services that are not Medically Necessary.

28. **Services for Members in the Custody of Law Enforcement Officers.** The Health Plan does not cover Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers. This does not apply to Services that are covered as out-of-Plan Emergency Services or out-of-Plan Urgent Care Services.

29. **Services Not Available in our Service Area.** The Health Plan does not cover Services not generally and customarily available in our Service Area. This does not apply when it is generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

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

31. **Sex change operations.** The Health Plan does not cover sex change operations, preparation for a sex change operation, complications arising from a sex change operation, or reversals of sex change operations.

32. **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. This includes, but is 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.

33. **Travel and Lodging Expenses.** The Health Plan does not cover travel and lodging expenses. We may pay certain expenses we preauthorize as part of the Health Plan's internal travel and lodging guidelines.

34. **Unclassified Medical Technology Devices and Services.** This Health Plan does not cover Medical technology devices and Services that are not 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 the Health Plan.

35. **Weight Management Facilities.** This Health Plan does not cover Services received in a weight management facility.

36. **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 costs for any such Services from the following sources:

    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.

    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

There may be events that cause a delay or cancellation of your covered services. Some 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 the Health Plan or Medical Group. We will use our best efforts to provide covered Services or make an arrangement for you to receive the covered Services.

In these instances, the Health Plan, the Medical Group and Medical Group physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving the Health Plan or Medical Group, we may postpone your care until the dispute is resolved if delaying your care is safe and will not be harmful to your health.

C. Third Party Liability

Third party liability means: someone other than you is or may be legally responsible for your condition or injury and the cost of treating your condition or injury.

If a third party is liable for your injury or illness, a Plan Provider will still provide the covered Services you need related to that injury or illness. The Health Plan has the right to bring a lawsuit against a third party in your name to be reimbursed for the cost of providing the covered Services you received under this EOC.

Your Obligations under Third Party Liability

If a third party is or may be liable to make payments for any benefits that are available under this plan, then the following must occur:

- You must repay the amount of benefits paid by the Health Plan in any settlement with the third party or the third party's insurance carrier.
- You must notify the Health Plan, in writing, of your claim against the third party.
- You must follow any rules of a liable third party payer prior to receiving non-Emergency Services.

You must help the Health Plan in situations involving third party liability. Please call **Member Services** if you have questions about Third Party Liability.

D. Surrogacy

Surrogacy is when a woman agrees to become pregnant and to give the baby to another person or couple who intend to raise the child. In a case where you receive payment to act as a surrogate, the Health Plan will seek repayment for covered Services you receive. This includes the Services in connection with the conception, pregnancy, and/or delivery of the child. This amount would not exceed the payment you receive to act as a surrogate.

E. Coordination of Benefits

Being eligible for **CHP+** means you do not have any other health insurance. If you are covered by any other valid insurance, you will no longer be eligible for **CHP+**.

If you get any other health insurance, please call **Member Services** and the Department. If you are found to have other health insurance, your coverage will be terminated (ended). The exceptions to have double coverage are Medicare and dental insurance.

X. APPEALS AND EXTERNAL REVIEW

A. Appeals

1. Your right to file an appeal of an action (decision)

   An appeal is when you try to change a decision, called an "action" that the Health Plan makes about your services. If the Health Plan takes an action, you and your provider will get a letter that tells you

why. This letter will explain how to appeal if you want to. This letter is also called a notice of action. If the action is about a denial of your request for payment, written notice of our decision will be provided in an "Explanation of Benefits" (EOB). This is also called a notice of action.

2. You can appeal any of the following actions:

   a. When we deny or limit a type or level of service you requested.

   b. When we reduce, suspend or stop a service that was previously approved.

   c. When we deny payment for any part of a service.

   d. When we do not provide or authorize (approve) services in a timely manner.

   e. When we do not act within timelines required by the state to provide notifications to you.

   A grievance is when you tell us or write to us and say you are dissatisfied about something that is not an action. Some examples may be, quality of care, improper behavior by provider or employee, or your rights were not respected. A grievance is also called a complaint. More information about how to file a grievance with the Health Plan is located in the "Member Satisfaction and Grievances Procedures" section.

3. Who may file your appeal?
   Your appeal may be filed by you or a Designated Client Representative (DCR). A DCR is someone you choose to talk for you about your appeal. A DCR can be a provider, an advocate, a lawyer, a family member, or any other person you trust and appoint. Your provider may file an appeal for you or help you with your appeal as your DCR. If you decide to use a DCR, you must sign a form with the name, address and phone number of your DCR. This is so we can contact the DCR during the appeal process. A DCR can also be the legal representative of a deceased member's estate. You may give us any information you feel we need to make a decision. To request a DCR form, please contact the Member **Appeals Program**.

4. How you can continue receiving services when you appeal
   a. If you are getting services that have already been approved by the Health Plan, you may be able to keep getting those services while you appeal if all of these requirements are met:

      i. your appeal has been sent to us by you or your DCR within the required timeframes;
      ii. a Health Plan provider or authorized provider has asked that you receive the services;
      iii. the time period for the authorization (approval) of services has not ended; and
      iv. you specifically request that the services continue.

   b. If you continue getting the approved services, they will continue until:

      i. you withdraw your appeal;
      ii. a total of 10 calendar days pass after we mail you our decision telling you that we are denying your appeal. If you request a State Fair Hearing within those 10 days, your benefits will continue until the hearing is finished; or
      iii. the State Fair Hearing office denies your appeal and upholds the Health Plan's decision.

   c. You will have to pay for services that you get during the appeal, if you lose the appeal. If you win the appeal, you will not have to pay. Please let us know when you ask for an appeal if you want to keep getting your services.

5. How much time do I get to appeal an action (decision)?
   The amount of time that you get to file an appeal is sixty (60) calendar days from the date on the Adverse Benefit Determination.

a. You or your DCR must request an appeal within sixty (60) calendar days from the date on the notice of action saying what action the Health Plan has taken, or plans to take if the appeal is about:
   i. a new request for services;
   ii. the partial or complete denial of a request to pay for services that you have already received; or
   iii. the reduction, suspension, or termination of a previously approved service (unless you make a request for benefits to continue during your appeal).

b. If you appeal an action to lower, change, or stop a previously authorized service and you want those services to continue during your appeal, you must file your appeal on time. On time for these type of actions means on or before the later of the following:

- Within ten (10) working days from the date of the notice of action; or
- The date that the action is intended to take effect.

6. How do I start my Appeal?
   a. To start your appeal of an action, you or your DCR can call the Member **Appeals Program**. If you call to start your appeal, you or your DCR must send us a letter after the phone call unless you or your DCR requests an expedited resolution. The letter must be signed by you or your DCR. We can help you with the letter, if you need help. The letter must be sent to: **Member Appeals Program, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066 Denver Colorado 80237-8066**. You or your DCR should send us all information that will help us understand why you think the Health Plan's action (decision) is not correct. Include the following information:

      i. your name and medical record number;
      ii. your medical condition or relevant symptoms;
      iii. the specific Services that you are requesting;
      iv. all the reasons you disagree with the Health Plan's action; and
      v. all supporting documents.

   b. You or your DCR can request a "rush" or expedited appeal if you are in the hospital, or feel that waiting for a regular appeal would threaten your life or health. Please see "Expedited (Rush) Appeals" below for more information.

   c. An appeal of a denial of a request for payment of services already received is not considered serious or life threatening. So, these types of appeals are not rushed or expedited. The right to a State Fair Hearing applies to payment denials.

7. What happens with an appeal?
   a. After we receive your phone call or letter, we will mail a letter to you or your DCR within two (2) business days. This letter will tell you that we got your request for an appeal.

   b. You or your DCR can tell us in person or in writing why you think the Health Plan should change its decision or action. You or your DCR can also give us any information or records that you think would help your appeal. You or your DCR can ask questions, and ask for the criteria or information we used to make our decision. You or your DCR can look at the Health Plan's medical records that have to do with your appeal. You or your DCR can contact **Member Services** to provide you or your DCR, without cost, copies of documents and other information about our decision or action you are appealing.

c. If the decision or action you are appealing is about a denial or change of services, a doctor will review your medical records and other information. This doctor will not be the same doctor who made the first decision. The Health Plan will make a decision and notify you or your DCR within ten (10) working days from the day we get your request. We will send you or your DCR a letter that tells you the decision and the reason for the decision.

d. We can extend the review time up to 14 calendar days if you ask us to. We can also extend the time if more information is needed and the delay is in your best interest. We will send you written notice explaining the delay. If we extend the timeframe, we will give you written notice of this within two (2) calendar days. We must resolve the appeal before the extension ends. You may file a grievance if you do not agree with the extension.

e. If you or your DCR requests an extension or if we need more information from your doctor, we will send you a letter to let you know we are extending our review for no more than fourteen (14) calendar days.

f. If your appeal is denied, you may request a State Fair Hearing within 120 calendar days from the date of the appeal decision or if Kaiser fails to process the appeal within the required timeframes.

8. Expedited (Rush) Appeals

You or your DCR can ask the Health Plan to expedite (rush) your appeal if you feel that waiting the usual amount of time for a decision would seriously affect your life, health, or ability to maintain or regain maximum function. The Health Plan can also decide on its own that your appeal should be expedited.

a. For a rush appeal, a decision would be made within seventy-two (72) hours, instead of ten (10) working days for a regular appeal. We will also try to call you with the results of the appeal.

b. Since there is a short amount of time to make a rush decision, you or your DCR have a short amount of time to look at our records, and a short amount of time to give us information in person or in writing. The information you need to give us includes:

i. your name and medical record number;
ii. your medical condition or relevant symptoms;
iii. the specific services that you are requesting;
iv. all the reasons you disagree with the Health Plan's action; and
v. all supporting documents.

c. If your request for a rush appeal is denied, the Health Plan will call you as soon as possible to let you know. We will also send you a letter within two (2) calendar days that will tell you that you may file a grievance if you disagree with our decision. Then we will review your appeal the regular way. You will get a letter that tells you the decision of the appeal and the reason.

B. External Review

1. How do I get external review in a State Fair Hearing?

A State Fair Hearing means that a State Administrative Law Judge (ALJ) will review the Health Plan's decision or action. We can help you get ready for your State Fair Hearing. You may ask for a State Fair Hearing:

- after you receive a decision about your appeal; or
- if you are not happy with the Health Plan's decision about your appeal.

a. A request for a State Fair Hearing must be in writing and signed by you or the DCR. The representative of a deceased member's estate may also be a party to the State Fair Hearing.

b. If you want to have an action reviewed, you or your DCR must make the request within 120 calendar days from the date on the notice of action. You do not have 120 calendar days to make your request for review, if you want to have your service continued during the State Fair Hearing process. If you want to request that previously authorized services continue during the State Fair Hearing, you or your DCR must make the request for a State Fair Hearing within ten (10) calendar days from the date on the notice of action, or before the effective date of the termination or change in service, whichever is later.

c. If you or your DCR want to ask for a State Fair Hearing, you or your DCR may call or write to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203
Phone: (303) 866-2000
Fax: (303) 866-5909

d. The Office of Administrative Courts will send you a letter that explains the State Fair Hearing process and will set a date for your hearing. You can talk for yourself at a State Fair Hearing or you can have a DCR talk for you. The ALJ will review the Health Plan's decision or action. Then the ALJ will make a decision.

e. If you are getting services that have already been approved by the Health Plan, you may be able to keep getting those services while you are waiting for the ALJ's decision. But if you lose at the State Fair Hearing, you may have to pay for services that you get while you are appealing. If you win, you will not have to pay. If you win the State Fair Hearing and you were not getting services while waiting on the decision, the Health Plan will promptly approve those for you within 72 hours from the date we receive the decision.

2. <u>The Health Plan can help you with the appeals process, language and translation</u>

The Health Plan will help you with completing any forms that we require, putting oral requests for a State Fair Hearing into writing and other procedural steps concerning the appeals process. To ask questions or get help contact **Member Services**.

The Health Plan's action (decision) on your appeal will be in writing and be available in English.

You may request that we provide the notice of action and our appeal decision in non-English languages. You may also ask us for assistance if you need oral translation services. You may request assistance by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.

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

XI. MEMBER SATISFACTION AND GRIEVANCES PROCEDURES

A grievance is when you tell us or write to us and say you are dissatisfied about something that is not an action. Some examples may be quality of care, improper behavior by provider or employee, or your rights were not respected. A grievance is also called a complaint.

A. When to File a Grievance

You may file a grievance (also called a complaint) if you are: (1) not happy with the Services you received; or (2) if you have a concern about the personnel or some other matter that relates to Services at a Plan Medical Office.

Filing a grievance is not the same as filing an appeal. An appeal is when you try to change a decision, called an "action" that the Health Plan makes about your Services. More information about how to file an appeal with the Health Plan is located in the "Appeals and External Review" section.

B. How to File a Grievance

1. You may file a grievance about something that is not an action subject to an appeal, such as your costs, copays, or premium. A Provider or a DCR may also file a grievance on your behalf. You may give us any information you feel we need to make a decision. To file a grievance follow the procedure listed below.
   a. Complete a Member Grievance/Complaint Form (located at the end of this EOC) and mail it to: **Customer Experience Department, Kaiser Foundation Health Plan of Colorado, 2500 South Havana Street, Aurora, CO 80014**; or
   b. Request to meet with a **Member Services** Liaison at the Health Plan Administrative Offices; or
   c. Call **Member Services**.
2. You may file a complaint at any time. After you notify us of a complaint, this is what happens:
   a. Within two (2) business days we will send you a letter saying that we got your complaint.
   b. A **Member Services** Liaison reviews the complaint and investigates it, verifying all the facts related to the case.
   c. The **Member Services** Liaison or a Plan Physician reviews the facts and recommend an action to correct the problem, if any. We will ensure that the people who make the decision on your grievance were not involved in any previous level of review or decision-making. If the complaint concerns your medical condition, the people making the decision will have the right medical knowledge to understand the problem.
   d. Within 15 business days after we get your letter, we will send you a letter saying what we found and how we fixed it. Sometimes we may not be able to fix it and if that happens we will let you know.
   e. We can extend the review time up to 14 calendar days if you ask us to. We can also extend the time if more information is needed and the delay is in your best interest. We will send you written notice explaining the delay. If we extend the timeframe, we will give you written notice of this within two (2) calendar days. We must resolve the grievance before the extension ends. You may file a grievance if you do not agree with the extension.
3. The Health Plan will help you with completing any forms that we require. To ask questions or get help, contact **Member Services**.

   The Health Plan's action (decision) on your complaint will be in writing and be available in English.

You may ask us for assistance if you need oral translation services. You may request assistance by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.

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

4. If the Health Plan approves your disenrollment in response to a grievance, we will provide enough time to disenroll based on time frames required by law.

If you are not happy with the outcome, you have the right to contact the Colorado Department of Health Care Policy & Financing. They will do another review. Their decision is final. You can contact them at: **Department of Health Care Policy & Financing, CHP+ Health Plan Manager, 1570 Grant Street, Denver, CO 80203**, telephone **303-866-3586**.

We want you to be satisfied with our Plan Facilities, Services, and Plan Physicians. Letting us know when you are not happy about the Services you received helps us to improve. It will give us the chance to correct any problems and make sure you are getting the health care you need. If you are not satisfied for any reason, please let us know by calling **Member Services**.

We also welcome the chance to gather member feedback about policy and operations. The **Kaiser Permanente Health Advisory Council** is a way for you to get involved. Your thoughts may make a difference in how Members receive health care. If you are interested in learning more about the **Kaiser Permanente Health Advisory Council**, please call **303-344-7630** for more information.

XII. GENERAL POLICY PROVISIONS

A. Access Plan

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

B. Access to Services for Foreign Language Speakers

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

C. 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 medical decisions if the person is unable to make an informed decision about medical treatment. (Colorado Revised Statutes, Section 15-14-504)

A health care provider or health care facility will provide for the prompt transfer of the Member to another health care provider or health care facility if they do not wish to comply with your medical treatment decision based on moral convictions or religious belief policies. (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**.

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.

Complaints concerning advance directive requirements may be filed with the **Colorado Department of Public Health and Environment**. For more information, please contact them at **303-692-2980**.

D. Changes to EOC

This EOC will change periodically. We will notify you of the changes. If we need to make revisions to this EOC, we will issue revised materials to you.

E. 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. No financial incentives exist that encourage denials of coverage or service that result in decreased use of services. If you would like more information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

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

F. Governing Law

This EOC will be governed by Colorado and federal law, and may be changed as those laws may require.

G. Nondiscrimination

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

H. Notices

Our notices to you will be sent to the most recent address we have for you. You are 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.

I. Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You 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 to receive confidential information at a different address or by another method.

We may use or disclose your PHI for treatment, payment and health care operations purposes. This includes quality improvement. Sometimes we may be required by law to give PHI to government agencies or in legal actions. We will not use or disclose your PHI for any other purpose without your (or your representative's) permission, except as described in our *Notice of Privacy Practices* (see below). Giving us permission is your choice.

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

J. Women's Health and Cancer Rights Act

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

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

XIII. MEMBER RIGHTS AND RESPONSIBILITIES

A. Member Rights

As a Member of Kaiser Permanente, you have the right to:

- get information in a way that is easy for you to understand, like plain language, large print, another language, or through a TTY/TDY phone line.
- be treated with respect for your personal dignity and the need for privacy.
- be a part of deciding what is best to do for your health care.
- talk about Medically Necessary treatment options for your condition, regardless of cost or benefit coverage, with the information presented in a way that you can understand.
- refuse recommended medical treatment or procedures.
- have your health, illness, and treatment information stay confidential.
- file a complaint or appeal about Kaiser Permanente or the care provided.
- offer suggestions for changes in the plan's quality improvement policies and procedures.
- get family planning services from a provider in or out of network without referral.
- get a copy of your or your minor child's(ren's) medical records and request corrections.
- information about Kaiser Permanente, its Services, the people providing care, and the Rights and Responsibilities of Members.
- exercise these rights without any adverse effect on the way you are treated.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.
- choose your physician.
- receive information about the outcomes of care you have received.
- express your wishes concerning future care.
- have a safe, secure, clean, and accessible environment.
- have impartial access to all medically indicated treatment that is a covered benefit, regardless of your race, religion, sex, sexual orientation, national origin, cultural background, disability, or financial status.

B. Member Responsibilities

As a Member of Kaiser Permanente, you have the responsibility to:

- follow instructions and guidelines from people providing health care Services.
- give your health care provider all information in order to care for you.
- keep appointments for care and to give required notice when canceling.
- pay your Copayment at the time Services are rendered.

- read and understand all materials about your health care coverage and to share this information with your health care provider.
- notify your Plan Physician within 24 hours after receiving Emergency care without a referral.
- treat the providers and Kaiser Permanente staff with respect and personal dignity.

XIV. DEFINITIONS

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

Adverse Benefit Determination: The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).

Appeal: A review by the Health Plan of an adverse benefit determination.

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

Department: The Colorado Department of Health Care Policy & Financing.

Designated Client Representative (DCR): A person you choose to talk for you on your behalf during an appeal or grievance. A DCR can be a provider, an advocate, a lawyer, a family member, or any other person you trust and appoint

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

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

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

1. A medical screening examination (as required by law) that is within the capability of the emergency department of a hospital. This includes ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment as required by law to Stabilize the patient.

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

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination, regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by Health Plan to make an authorization decision.

Habilitation Services: Outpatient physical, occupational, and speech therapies and devices that help you keep, learn, or improve skills and functioning for daily living.

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

Kaiser Permanente: Health Plan and Medical Group.

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

Medically Necessary (Medical Necessity): A covered Service is deemed Medically Necessary, if in a manner consistent with accepted standards of medical practice, it is:

- Consistent with the symptom, diagnosis and treatment of a Member's medical condition;
- Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence;
- Not experimental, investigational, unproven, unusual or not customary;
- Not solely for cosmetic purposes;
- Not solely for the convenience of the Member, Physician or other Provider;
- The most appropriate level of care that can be safely provided to the Member; and
- Failure to provide the Covered Service would adversely affect the Member's health.
- When applied to inpatient care, Medically Necessary further means that covered Services cannot be safely provided in an ambulatory setting.

The fact that a provider may prescribe, order, recommend, or approve a service does not of itself make the service Medically Necessary.

Member: A person who is eligible and enrolled under this EOC. This EOC sometimes refers to Member as "you" or "your."

Occupational Therapy: Therapy based on engagement in meaningful activities of daily life (such as self-care skills, education, work, or social interaction), especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.

Out-of-Pocket Maximum: The total amount you must pay in a calendar year for covered Services. The Out-of-Pocket Maximum is designed to protect members from catastrophic healthcare expenses. For each member's calendar year, after the Out-of-Pocket Maximum is reached, for most covered Services, payment will be made at 100% of the allowable charge for the remainder of that calendar year.

Physical Therapy: Therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by disability, injury, or disease that utilizes therapeutic exercise, physical modalities, assistive devices, and patient education and training.

Plan Facility: A Plan Medical Office or Plan Hospital.

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

Plan Medical Office: Any medical office listed in our provider directory. Plan Medical Offices are subject to change at any time without notice.

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

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

Plan Physician: Any licensed physician who is an employee of the Medical Group or any licensed physician who contracts to provide Services to Members. This does not include physicians who contract only to provide referral Services.

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

Prior Authorization: A written approval or consent given by Health Plan before treatment or Services are obtained.

Rehabilitation Services: Physical, occupational, and speech therapies and devices that help you recover from an acute injury, illness, or surgery.

Service Area: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson 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 the Health Plan. The facility's primary business must be to provide 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing and/or skilled rehabilitation care on a daily basis, as part of an ongoing medical treatment plan.

Speech Therapy: Therapeutic treatment of speech defects.

Stabilize: To provide the medical treatment of the Emergency Medical Conditions that is needed to:

- assure, within reasonable medical probability that no material deterioration of the condition is likely to result from the transfer; or
- happen during the transfer of the person from the facility.

For a pregnant woman who is having contractions, "Stabilize" means to deliver (including the placenta) when:

- there is not enough 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.

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

KAISER PERMANENTE®

Customer Experience Department
2500 South Havana St
Aurora, Colorado 80014
Fax: 303-338-3220

Member Grievance/Complaint Form

You may use this form to file a grievance/complaint. Please attach any documents you have to support your request. Please mail or fax this form and all supporting documents to the address and/or fax number listed above. Your complaint will be responded to in writing within 30 calendar days following receipt. For our CHP+ members, your complaint will be responded to in writing within 15 calendar days.

If you have questions please contact Member Services, Denver/Boulder and Northern Colorado, and our Mountain service areas, please call 303-338-3800, toll-free at 1-800-632-9700, between 8 a.m. to 5 p.m., Monday through Friday.

For Colorado Springs please call, 1-888-861-7878. For the hearing or speech impaired, **TTY 711.** You may also contact our department through our website at **kaiserpermanente.org.**

Member Name:	Health Record Number:
Home Phone:	Cell Phone:
Address:	

If you are not the member, please provide the following information:

Your Name:	Relationship to Member(if applicable):
Your Phone Number(s):	
Your Address:	

KAISER PERMANENTE®

Are you the member's authorized representative or legal guardian? Yes ☐ No ☐

Note: we must have written authorization to allow you to act on the member's behalf if you are not their authorized representative or legal guardian.

Please explain your complaint. Include, if available, the following information:

- The name of the provider(s) and/or staff member(s) who will or has provided care:
- The date(s) of service;
- The specific details of the interaction and/or care; and
- The specific reason(s).

Grievance/Complaint Details:

Signature: _____Date:_____

For Use by Kaiser Permanente Only:

Specialist Name:	Location:	Date:

NONDISCRIMINATION NOTICE

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

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

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

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

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

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

HELP IN YOUR LANGUAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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