TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

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

This EOC is for your Group's 2026 contract year.

kp.org

KAISER PERMANENTE®

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary 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, braille, and accessible electronic formats

- Provides 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, ancestry, age, disability, sex,(including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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**, (TTY **1-800-537-7697**). Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available at

https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice

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HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት ሞርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-632-9700** (TTY **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Ɓàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yé, mbi èyɛm. Wɔ nàŋ **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700**（TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-632-9700** (TTY (تلفن متنی) **711**) تماس بگیرید.

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY **711**).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesịrị ekwesị, n'efu, dị nye gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-632-9700** までお電話ください（TTY：**711**）。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700** 로 전화해 주세요(TTY **711**).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę́', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: यदि तपाइँ नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, नि:शुल्क उपलब्ध छन्। फोन **1-800-632-9700** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Yorùbá, àwọn iṣẹ́ ìrànlọ́wọ́ èdè tó fi kún àwọn ohun èlò ìrànlọ́wọ́ tó yẹ àti àwọn iṣẹ́ láìsí ìdíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

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

III. COPAYMENTS AND COINSURANCE

IMPORTANT INFORMATION: PLEASE READ

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

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

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

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

1. For a Service to be a covered Service:
   a. The Service ***must be*** Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service ***must be*** provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service ***must be*** described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are ***not*** always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

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

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

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

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible:

   Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

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

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

A. For covered Services that **APPLY** toward the OPM:
   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM Copayments or Coinsurances apply toward the OPM unless otherwise specified "III. Copayments and Coinsurance".
   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** toward the OPM for the rest of the Accumulation Period.

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

Tracking Pharmacy Deductible(s) and Out-of-Pocket Amounts

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

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

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum

Note: Covered services apply to the Out-of-Pocket Maximum unless otherwise specified.

Embedded Out-of-Pocket Maximum An Embedded OPM means: • Each individual family Member has their own OPM. • If you reach your individual OPM before the family OPM is met, you will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	$3,000/Individual per Accumulation Period $6,000/Family per Accumulation Period

Covered services apply to the Out-of-Pocket Maximum unless otherwise specified.	
Office Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits	Visit: $20 Copayment each visit
Specialty care visits	Visit: $35 Copayment each visit
Consultations with clinical pharmacists	Visit: $20 Copayment each visit
Allergy evaluation and testing	
• Primary care visits	Visit: $20 Copayment each visit
• Specialty care visits	Visit: $35 Copayment each visit
Allergy injections	Visit: $20 Copayment each visit An additional charge may apply for allergy serum.
Gynecology care visits	Visit: $35 Copayment each visit
Routine prenatal and postpartum visits	No Charge
• Doula Services (prenatal and postpartum support)	Visit limits are combined between in-person and video visits for prenatal and postpartum Services.
○ Up to eleven (11) visits for the following:	
■ In-person visit	No Charge
■ Video visits	No Charge
Office administered drugs	20% Coinsurance
• Travel immunizations	Not Covered
Virtual Care Services	
• Chat with a provider online	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge
• Email	
○ Primary care visits	No Charge

○ Specialty care visits	No Charge
• E-visits	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge
• Telephone visits	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge
• Video visits	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge

Outpatient Hospital and Surgical Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities	Ambulatory surgical center: $100 Copayment each surgery Outpatient hospital: $100 Copayment each surgery
Outpatient hospital Services, including direct admission to observation care	20% Coinsurance up to $100 per visit

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.)	No Charge per admission
Inpatient professional Services	No Charge per admission
Doula Services (labor support) • Limited to one (1) inpatient visit per pregnancy	No Charge per admission

Alternative Medicine	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Chiropractic Care	
• Evaluation and/or Manipulation	$20 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or X-rays required for chiropractic care	See "X-ray, Laboratory, and Advanced Imaging Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services	Not Covered

Ambulance Services	You Pay
Ambulance Services	$25 Copayment each trip

Bariatric Surgery	You Pay
Bariatric Surgery	50% Coinsurance

Dental Services following Accidental Injury	You Pay
Dental Services following Accidental Injury	Not Covered

Dialysis Care	You Pay
Dialysis Care	$35 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment	No Charge
• Milk pumps (also known as breast pumps)	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices	See “Outpatient Hospital and Surgical Services” and “Hospital Inpatient Care” for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg	No Charge
• All other prosthetic devices	No Charge
Orthotic devices	No Charge
Oxygen	No Charge
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and Out-of-Plan emergency department visits and related covered Services unless otherwise noted (covered 24 hours a day)	$75 Copayment each visit Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. For advanced imaging procedures, see “X-ray, Laboratory, and Advanced Imaging Procedures” for applicable Copayment or Coinsurance.

Plan and Out-of-Plan emergency department observation care	$75 Copayment each visit Emergency department Copayment is waived if you receive emergency care and then are transferred to observation care. If the above amount is a Coinsurance, the Coinsurance is applied to both the emergency department care and the observation care. If you are directly admitted to observation care, see “Outpatient hospital Services” for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and Out-of-Plan urgent care	$20 Copayment each visit

Family Planning and Sterilization Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Family planning counseling	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.
Procedure for the interruption of pregnancy (abortion)	Any exclusions listed below also apply to interruption of pregnancy (abortion) drugs.
• Elective interruption of pregnancy	No Charge
• Therapeutic interruption of pregnancy	No Charge
Vasectomy procedures	No Charge

Health Education Services	**You Pay**
Training in self-care and preventive care	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	**You Pay**
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist	$20 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist	$35 Copayment each visit
Hearing aids for Members up to age 18	$20 Copayment each visit

• Fitting and recheck visits	$20 Copayment each visit
Hearing aids for Members age 18 and over	Not Covered
• Fitting and recheck visits	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care	No Charge
Hospice care for terminally ill patients	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No Charge
Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization	No Charge
Individual office visits	Visit: $20 Copayment each visit
Group office visits	Visit: $10 Copayment each visit
Intensive outpatient therapy or partial hospitalization	Visit: No Charge

Out-Of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area.	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)*	Visit limit: Limited to 10 visits per Accumulation Period Visit: $20 Copayment each visit Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services	Diagnostic X-ray limit:Limited to 10 diagnostic x-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits	Therapy visit limit:Limited to 10 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment each visit

Outpatient prescription drugs • Copayment/Coinsurance (except as listed below)	Prescription drug fills: Limited to 12 prescription drug fills (any combination) per Accumulation Period 50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies	20% Coinsurance
• Preventive drugs ○ Contraceptive drugs	No Charge
○ Over the counter (OTC) items *(Federally mandated over the counter items)*	No Charge
○ Tobacco cessation drugs	No Charge

Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Inpatient treatment in a designated rehabilitation facility	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits	
• Habilitative Services	Visit limits are combined between in-person visits and video visits.
○ Physical therapy ▪ In-person visit	$20 Copayment each visit
▪ Video visits	$20 Copayment each visit
○ Occupational therapy ▪ In-person visit	$20 Copayment each visit
▪ Video visits	$20 Copayment each visit
○ Speech therapy ▪ In-person visit	$20 Copayment each visit
▪ Video visits	$20 Copayment each visit
• Rehabilitative Services	Visit limits are combined between in-person visits and video visits.
○ Physical therapy ▪ In-person visit	$20 Copayment each visit
▪ Video visits	$20 Copayment each visit
○ Occupational therapy ▪ In-person visit	$20 Copayment each visit
▪ Video visits	$20 Copayment each visit

○ Speech therapy	
■ In-person visit	$20 Copayment each visit
■ Video visits	$20 Copayment each visit
• To treat Autism Spectrum Disorder	
○ Physical therapy	
■ In-person visit	$20 Copayment each visit
■ Video visits	$20 Copayment each visit
○ Occupational therapy	
■ In-person visit	$20 Copayment each visit
■ Video visits	$20 Copayment each visit
○ Speech therapy	
■ In-person visit	$20 Copayment each visit
■ Video visits	$20 Copayment each visit
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) to treat Autism Spectrum Disorder	$20 Copayment each visit
• Applied Behavior Analysis (ABA) video visits to treat Autism Spectrum Disorder	No Charge
Cardiac rehabilitation	
• In-person visit	$20 Copayment each visit
• Video visits	No Charge
Pulmonary rehabilitation	
• In-person visit	$20 Copayment each visit
• Video visits	No Charge

Prescription Drugs, Supplies, and Supplements	**You Pay**
See Additional Provisions if your Group has purchased coverage for outpatient prescription drugs.	
Note: Coverage is subject to the drug formulary restrictions and guidelines.	
Outpatient prescription drugs	Prescriptions are not subject to the pharmacy Deductible unless otherwise listed in this "Prescription Drugs, Supplies, and Supplements" section.
• Pharmacy Deductible	Not Applicable

• Day Supply Limit	30 days
• Copayment/Coinsurance (except as listed below)	$10 Generic Preferred/$10 Generic Non-Preferred/$30 Brand Preferred/$30 Brand Non-Preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs	See applicable Outpatient prescription drug Copayment or Coinsurance
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply of all prescription insulin drugs.
○ Diabetic supplies (When obtained from sources designated by Kaiser Permanente)	20% Coinsurance
• Interruption of pregnancy (abortion) drugs	See “Family Planning and Sterilization Services” for any applicable exclusions.
• Preventive drugs	No Charge
○ Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente Pharmacy.)*	No Charge (Not subject to pharmacy Deductible)
○ Prescription contraceptives *(Supply limit according to applicable law)*	No Charge
○ Tobacco cessation drugs	No Charge (Not subject to pharmacy Deductible)
• Preventive maintenance drugs	See applicable Outpatient prescription drug Copayment or Coinsurance
• Sexual dysfunction drugs	Not Covered
• Sexual transmitted infection (STI) drugs	No Charge
• Specialty drugs	20% with $250 maximum
• Weight loss drugs	Not Covered
Mail-order	
• Copayment/Coinsurance	$20 Generic Preferred/$20 Generic Non-Preferred/$60 Brand Preferred/$60 Brand Non-Preferred See Additional Provisions
• Supply Limit	Up to 90 days

Preventive Care Services	You Pay
Preventive care visits • Adult preventive care exams and screenings • Mental health wellness examination • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services • Chat with a provider online • Email • E-visits • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
Reconstructive Surgery	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility	See “Office Services”, “Prescription Drugs, Supplies, and Supplements”, “X-ray, Laboratory, and Advanced Imaging Procedures”, or appropriate section for applicable Copayment or Coinsurance.
Intrauterine insemination (IUI)	$100 Copayment per procedure
In Vitro Fertilization (IVF)	$100 Copayment per procedure
Gamete Intrafallopian Transfer (GIFT)	$100 Copayment per procedure
Zygote Intrafallopian Transfer (ZIFT)	$100 Copayment per procedure
Standard fertility preservation Services **Note**: There is a limit of one (1) year of storage for gametes and embryos unless specified under “You Pay”.	$100 Copayment

Skilled Nursing Facility Care	You Pay
Skilled Nursing Facility Care	No Charge Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification	No Charge
Inpatient professional Services for medical detoxification	No Charge
Individual office visits	Visit: $20 Copayment each visit
Group office visits	Visit: $10 Copayment each visit
Intensive outpatient therapy or partial hospitalization	Visit: No Charge
Residential rehabilitation	No Charge per inpatient admission
Non-opioid treatment for pain • Up to six visits for each of the following:	
○ Acupuncture Services	$20 Copayment each visit
○ Chiropractic care	$20 Copayment each visit
○ Physical therapy	$20 Copayment each visit
○ Occupational therapy	$20 Copayment each visit

Transplant Services	You Pay
Transplant Services	See appropriate section in this Schedule of Benefits for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See “Office Services” for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Up to the end of the calendar year the Member turns age 19	Visit: $20 Copayment each visit Refraction Test: $20 Copayment each visit
• Members age 19 and over	Visit: $20 Copayment each visit Refraction Test: $20 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Up to the end of the calendar year the Member turns age 19	Visit:$35 Copayment each visit Refraction Test:$35 Copayment each visit
• Members age 19 and over	Visit: $35 Copayment each visit Refraction Test:$35 Copayment each visit
Optical hardware	
• Up to the end of the calendar year the Member turns age 19	Not Covered
• Members age 19 and over	Not Covered

X-ray, Laboratory, and Advanced Imaging Procedures	You Pay
Diagnostic laboratory Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals)	No Charge
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital	No Charge
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals)	No Charge
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital	No Charge
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital	$35 Copayment each visit
Advanced imaging procedures including but not limited to CT, PET, MRI, nuclear medicine • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office administered drugs".)*	$100 Copayment per procedure Copayment waived if an advanced imaging procedure is performed during an Emergency Department visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits.	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits.	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, and diagnostic X-ray and laboratory Services.	Not Covered
Prescription drug fill maximum per Accumulation Period	Not Applicable

• Outpatient prescription drugs filled at an out-of-Plan Pharmacy	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy	Not Covered

Eligibility Amendments

- Dependent Limiting Age

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

- Domestic Partner

  Your Group coverage includes health benefits for both same- and opposite-sex domestic partners and their Dependents. To be covered they must meet:
  1. The eligibility requirements as described in the “Eligibility” section of this EOC; and
  2. The conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

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

- Grandchildren

  Under your Group contract, a grandchild of you or your Spouse can be enrolled as your Dependent in this health benefit plan. This includes an adopted or foster grandchild. The grandchild must meet all Group and Health Plan eligibility requirements.

Group-Specific Coverage

- Eligible Organization

  This plan covers federally mandated over-the-counter non-prescription female contraceptive drugs and devices.

Additional Provisions

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

CONTACT US

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

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

Clinical Contact Center (to schedule an appointment)

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

Behavioral Health

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

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

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

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** **Waterpark I** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Utilization Management

CALL	Toll free **1-800-632-9700** (Member Services**)**
TTY	**711**

	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-529-0934**
WRITE	**Utilization Management** **Kaiser Foundation Health Plan of Colorado** **Waterpark I** **2500 South Parker Road** **Aurora, CO 80014-1622**

Member Relations (to file an appeal)

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

Claims Department

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

Membership Administration

WRITE	**Membership Administration** **Kaiser Permanente** **P.O. Box 203004** **Denver, CO 80220-9004**

Transplant Administrative Offices

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS (WHO PAYS WHAT)
TITLE PAGE (COVER PAGE)
CONTACT US
TABLE OF CONTENTS
I. ELIGIBILITY 1
A. Who Is Eligible 1
1. General 1
2. Subscribers 1
3. Dependents 1
B. Enrollment and Effective Date of Coverage 1
1. New Employees and their Dependents 1
2. Members Who are Inpatient on Effective Date of Coverage 1
3. Special Enrollment Due to Newly Acquired Dependents 1
4. Special Enrollment 2
5. Open Enrollment 2
6. Persons Barred from Enrolling 2
II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 2
A. Your Primary Care Provider 3
1. Choosing Your Primary Care Provider 3
2. Changing Your Primary Care Provider 3
B. Access to Other Providers 3
1. Referrals and Authorizations 3
2. Specialty Referrals 3
3. Second Opinions 4
C. Plan Facilities 4
D. Getting the Care You Need 4
E. Visiting Other Kaiser Regional Health Plan Service Areas 4
F. Using Your Health Plan Identification Card 4
III. BENEFITS/COVERAGE (WHAT IS COVERED) 5
A. Office Services 5
B. Outpatient Hospital and Surgical Services 6
C. Hospital Inpatient Care 6
1. Inpatient Services in a Plan Hospital 6
2. Hospital Inpatient Care Exclusions 7
D. Ambulance Services and Other Transportation 7
1. Coverage 7
2. Ambulance Services Exclusions 7
E. Clinical Trials 7
1. Coverage **(applies to non-grandfathered health plans only)** 7
2. Clinical Trials Exclusions 7
F. Dialysis Care 7
G. Doula Services 8
H. Durable Medical Equipment (DME) and Prosthetics and Orthotics 8
1. Durable Medical Equipment (DME) 8
2. Prosthetic Devices 9
3. Orthotic Devices 9
I. Early Childhood Intervention Services 9
1. Coverage 9
2. Limitations 9
3. Early Childhood Intervention Services Exclusions 9
J. Emergency Services and Urgent Care 9
1. Emergency Services 10

2. Urgent Care ... 11
K. Family Planning and Sterilization Services ... 12
1. Coverage ... 12
2. Family Planning and Sterilization Services Exclusions ... 12
L. Gender Affirming Health Services ... 12
1. Coverage ... 12
2. Gender Affirming Health Services Exclusions ... 12
M. Health Education Services ... 12
N. Hearing Services ... 13
1. Members up to Age 18 ... 13
2. Members Age 18 Years and Over ... 13
O. Home Health Care ... 13
1. Coverage ... 13
2. Home Health Care Exclusions ... 13
P. Hospice Special Services and Hospice Care ... 13
1. Hospice Special Services ... 13
2. Hospice Care ... 13
Q. Mental Health Services ... 14
1. Coverage ... 14
2. Mental Health Services Exclusions ... 14
R. Out-of-Area Benefit ... 14
1. Coverage ... 14
2. Out-of-Area Benefit Exclusions and Limitations ... 15
S. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services ... 15
1. Coverage ... 15
2. Limitations ... 16
3. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services Exclusions ... 16
T. Prescription Drugs, Supplies, and Supplements ... 16
1. Coverage ... 16
2. Limitations ... 17
3. Prescription Drugs, Supplies, and Supplements Exclusions ... 17
U. Preventive Care Services ... 18
V. Reconstructive Surgery ... 18
1. Coverage ... 18
2. Reconstructive Surgery Exclusions ... 18
W. Reproductive Support Services ... 18
1. Coverage ... 18
2. Limitations ... 18
3. Reproductive Support Services Exclusions ... 19
X. Skilled Nursing Facility Care ... 19
1. Coverage ... 19
2. Skilled Nursing Facility Care Exclusion ... 19
Y. Substance Use Disorder Services ... 19
1. Inpatient Medical and Hospital Services ... 19
2. Residential Rehabilitation ... 19
3. Outpatient Services ... 19
4. Substance Use Disorder Services Exclusion ... 19
Z. Transplant Services ... 19
1. Coverage for Members who are transplant recipients ... 19
2. Coverage for Members who are living organ donors ... 20
3. Terms and Conditions ... 20
4. Transplant Services Exclusions and Limitations ... 20
AA. Vision Services ... 20
1. Coverage ... 20
2. Vision Services Exclusions ... 20
BB. X-ray, Laboratory, and Advanced Imaging Procedures ... 20

1. Coverage 20
2. X-ray, Laboratory, and Advanced Imaging Procedures Exclusions 21

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED) 21

A. Exclusions 21
B. Limitations 24
C. Reductions 24
1. Coordination of Benefits (COB) 24
2. Injuries or Illnesses Alleged to be Caused by Other Parties 27
3. Surrogacy Arrangements: Traditional or Gestational Carriers 28

V. MEMBER PAYMENT RESPONSIBILITY 28

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM) 29

VII. GENERAL POLICY PROVISIONS 29

A. Access Plan 29
B. Access to Services for Foreign Language Speakers 29
C. Administration of Agreement 29
D. Advance Directives 29
E. Agreement Binding on Members 30
F. Amendment of Agreement 30
G. Applications and Statements 30
H. Assignment 30
I. Attorney Fees and Expenses 30
J. Claims Review Authority 30
K. Contracts with Plan Providers 30
L. **Extra Services** 30
M. **Genetic Testing Information** 31
N. Governing Law 31
O. Group and Members are not Health Plan's Agents 31
P. No Waiver 31
Q. Nondiscrimination 31
R. Notices 31
S. Out-of-Pocket Maximum Takeover Credit 32
T. Overpayment Recovery 32
U. Privacy Practices 32
V. Women's Health and Cancer Rights Act 32

VIII. TERMINATION/NONRENEWAL/CONTINUATION 32

A. Termination Due to Loss of Eligibility 33
B. Termination of Group Agreement 33
C. Termination for Cause 33
D. Termination for Nonpayment 33
E. Termination of a Product or all Products (applies to non-grandfathered health plans only) 33
F. Rescission of Membership 33
G. Continuation of Group Coverage Under Federal Law, State Law or USERRA 33
1. Federal Law (COBRA) 33
2. State Law 34
3. USERRA 34
H. Moving Outside of our Service Area 34
I. Moving to Another Kaiser Regional Health Plan Service Area 34

IX. APPEALS AND COMPLAINTS 34

A. Claims and Appeals 34
B. Complaints 42

X. INFORMATION ON POLICY AND RATE CHANGES 42

XI. DEFINITIONS 42

ADDITIONAL PROVISIONS

I. ELIGIBILITY

A. Who Is Eligible

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

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

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

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

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

   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. The group is responsible for reviewing proof of the dependent's disability and dependency.

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

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

   If your plan has different eligibility requirements, please see the "Eligibility Amendments" section of the "Schedule of Benefits (Who Pays What)" and/or the "Additional Provisions."

B. Enrollment and Effective Date of Coverage

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

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

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

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

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:
   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

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

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

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

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

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

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

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

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

A. Your Primary Care Provider

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

1. Choosing Your Primary Care Provider

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

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

2. Changing Your Primary Care Provider

   Please call the **Clinical Contact Center** to change your PCP. You may also change your PCP online or when visiting a Kaiser Permanente Medical Office Building. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

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

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

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

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

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

2. Specialty Referrals

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

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

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

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

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

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

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

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

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

D. Getting the Care You Need

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

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

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization; Deductible; Copayment; Coinsurance; limitations and exclusions, as further described online at kp.org/travel. Certain services are not covered as visiting member services.

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

F. Using Your Health Plan Identification Card

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

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

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

III. BENEFITS/COVERAGE (WHAT IS COVERED)

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

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

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

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

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You will also be required to pay any amount in excess of eligible Charges and any amount for Services provided by an Out-of-Plan Provider when you consent to their provision of Services. You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits; Emergency Services; urgent care; and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

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

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

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown in the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

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

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

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

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

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

   Note: Services provided during post-surgical office visits may have a cost-share.

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram; sleep study; stress test; pulmonary function test; any treatment room; or direct admission to any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

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

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

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

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning.
      Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. All charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Doula Services to provide labor support (see "Doula Services" in this "Benefits/Coverage (What is Covered)" section for more details).
   g. Meals and special diets.
   h. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

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

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

D. Ambulance Services and Other Transportation

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

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

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

E. Clinical Trials

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

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

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

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

F. Dialysis Care

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

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

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Doula Services

1. Coverage
   We cover Doula Services provided for pregnant people during pregnancy, childbirth, the postpartum period, and supportive services if the pregnancy ends in stillbirth or miscarriage. Doulas offer nonmedical support, guidance, evidence-based education, practical support during childbirth, and linkages to community-based resources.
   a. Prenatal support services, including emotional support, guidance, and education on caring for a newborn, to prevent adverse outcomes;
   b. Labor support; and
   c. Postpartum support to improve member outcomes.
2. Limitations
   a. Doula Services are limited to eleven (11) combined visits per pregnancy for prenatal and postpartum services. Visits can be in person or virtual; and
   b. Labor support is limited to one (1) inpatient visit per pregnancy.
3. Doula Services Exclusions
   a. Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care);
   b. Help with activities of daily living (such as shopping or laundry);
   c. Alternative or complementary services (such as aromatherapy, birth education, or massage therapy);
   d. Yoga;
   e. Birthing ceremonies (such as sealing or closing the bones);
   f. Over-the-counter supplies or drugs;
   g. Home birth;
   h. Belly binding (traditional or ceremonial);
   i. Massage (maternal or infant);
   j. Photography;
   k. Placenta encapsulation;
   l. Vaginal steams;
   m. Group classes on baby wearing; and
   n. Support during abortion (medication administration and or procedure).

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

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

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

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

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

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

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

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

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

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

I. Early Childhood Intervention Services

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

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

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

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

J. Emergency Services and Urgent Care

1. Emergency Services

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

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

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

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

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

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

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

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

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

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

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the Emergency Medical Condition.

ii. Emergency Services Limitation for Out-of-Plan Providers

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

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

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

b. Emergency Services Exclusions and Limitations

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

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

c. Payment

Our payment is reduced by:

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

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

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

2. Urgent Care

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

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

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

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

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

K. Family Planning and Sterilization Services

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

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

2. Family Planning and Sterilization Services Exclusions
   Any and all Services to reverse voluntary, surgically induced sterilization.

L. Gender Affirming Health Services

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

1. Coverage

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

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

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

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

M. 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.

N. Hearing Services

1. Members up to Age 18

   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:

   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to: the initial assessment; fitting; adjustments; and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Over

   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions

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

O. Home Health Care

1. Coverage

   We cover skilled nursing care, home infusion therapy, physical therapy, occupational therapy, speech therapy, home health aide Services, and medical social Services:

   a. only on an Intermittent Care basis (as described below); and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

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

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

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

2. Home Health Care Exclusions

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

P. Hospice Special Services and Hospice Care

1. Hospice Special Services

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

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

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

2. Hospice Care

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

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

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

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

Q. Mental Health Services

1. Coverage

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

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

b. Inpatient Services

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

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

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

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

R. Out-of-Area Benefit

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

1. Coverage

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

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

b. Diagnostic X-rays.

c. Physical, occupational, and speech therapy visits.

d. Prescription drug fills.

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

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

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

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

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

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

   d. Cardiac Rehabilitation
      We cover treatment in a cardiac rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

   e. Pulmonary Rehabilitation
      We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

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

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

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

   g. Therapies for the Treatment of Autism Spectrum Disorders
      For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
      i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."

ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

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

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

T. Prescription Drugs, Supplies, and Supplements

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

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

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

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

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

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

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

      Note: For non-grandfathered health plans, we cover twelve (12) months of a prescription contraceptive at one time.

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

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

b. Outpatient Prescription Drugs

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

i. Prescriptions by Mail

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

ii. Specialty Drugs

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

c. Food Supplements

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

d. Diabetic Supplies and Accessories

Diabetic supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

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

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

Note: For more information regarding what your Group has purchased, 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. If you experience a severe adverse reaction from a covered countermeasure, please visit hrsa.gov/cicp.
b. Some drugs may require prior authorization.
c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions

a. Drugs for which a prescription is not required by law.
b. Disposable supplies for home use such as: bandages; gauze; tape; antiseptics; dressings; and ace-type bandages.
c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
d. Any packaging except the dispensing pharmacy's standard packaging.
e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
f. Prescription drugs received from a pharmacy for infertility services, unless prescription drug coverage is purchased.
g. Drugs to shorten the length of the common cold.
h. Drugs to enhance athletic performance.

i. Drugs for the treatment of weight loss, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
j. Drugs available over the counter and by prescription for the same strength.
k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
l. Unless approved by Health Plan, drugs not approved by the FDA.
m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
n. Prescription drugs necessary for Services excluded under this EOC.
o. Drugs administered during a medical office visit. See "Office Services."
p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."

U. Preventive Care Services

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

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

Preventive Services may help you stay healthy. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

V. Reconstructive Surgery

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

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

W. Reproductive Support Services

Note: If your Group is a religious purchaser, the coverage shown below may not apply to you. See the "Schedule of Benefits (Who Pays What)" to determine what coverage, if any, your Group has purchased.

1. Coverage
   We cover Services for the diagnosis and treatment of involuntary infertility, including Services for Members who may experience future impairment to their fertility due to medical treatment, or are unable to reproduce due to factors associated with their partner or lack of partner. The following Services are covered as shown in the "Schedule of Benefits (Who Pays What)":
   a. Office visits.
   b. Services including, but not limited to, X-ray and laboratory tests.
   c. Intrauterine insemination (IUI).
   d. In Vitro Fertilization (IVF).
   e. Gamete intrafallopian transfer (GIFT).
   f. Zygote intrafallopian transfer (ZIFT).
   g. Standard fertility preservation Services when done before a medical treatment that may cause infertility, such as radiation therapy or chemotherapy (e.g. iatrogenic infertility).
   h. Office administered drugs supplied and used during an office visit for IUI, IVF, GIFT, or ZIFT.
   i. Medically necessary pre-implantation genetic screening or pre-implantation genetic testing for aneuploidy (PGS/PGT-A).

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

2. Limitations
   a. There must be a diagnosis of involuntary infertility before any and all Services are covered.
   b. There is a limit of three (3) completed oocyte retrievals during the entire time you are enrolled in this plan.
   c. There are unlimited embryo transfers, using single embryo transfer when recommended and medically appropriate.
   d. There is a limit of one (1) year of storage for gametes and embryos.

e. Services are covered only for the person who is the Member.

3. Reproductive Support Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Any and all Services related to the procurement and/or storage of donor semen, eggs, and embryos.
   c. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   d. Prescription drugs received from a pharmacy for infertility services, unless prescription drug coverage is purchased.
   e. Any and all Services related to elective cryopreservation (e.g. elective egg freezing). This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, embryos, or other reproductive materials.

X. Skilled Nursing Facility Care

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

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

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

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

Y. Substance Use Disorder Services

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

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

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

3. Outpatient Services
   a. We cover individual office visits and group office visits.
   b. We cover partial hospitalization and intensive outpatient therapy.
   c. We cover visits for the purpose of monitoring drug therapy.
   d. We cover substance use disorder Services intended to reduce, eliminate, or avoid the use of opioids for persons with chronic pain conditions. Coverage includes up to six visits for each of the following: Acupuncture Services, Chiropractic care, Physical therapy, and Occupational therapy.

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

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

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

Z. Transplant Services

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

bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.
c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.
d. Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant.
e. These Services must be directly related to a covered transplant for you.

2. Coverage for Members who are living organ donors

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

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Health Plan. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.
   b. Plan Providers must determine that you meet Utilization Management Program Criteria before you receive Services.
   c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Health Plan. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Health Plan selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.
   d. After referral, if a Plan Provider or the medical staff of the referral facility determines you do not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

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

AA. Vision Services

1. Coverage

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

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

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as: eyeglass holders; eyeglass cases; repair kits; contact lens cases; contact lens cleaning and wetting solution; and lens protection plans.
   e. 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).
   f. Orthoptic (eye training) therapy or low vision therapy.

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

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

1. Coverage
   a. Outpatient

We cover the following Services:

i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

iii. Therapeutic X-ray Services and materials.

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

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

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

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

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

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

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

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

3. **Certain Maternity Services that are not Medically Necessary.** Certain maternity Services that are not Medically Necessary, including but not limited to: home birth Services.

4. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. Examples of this include cosmetic surgery related to bariatric surgery and hair prostheses due to hair loss. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

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

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local

anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma, or (c) Medically Necessary Services required for the direct treatment of a covered transplant procedure for a Member who is a transplant recipient. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

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

7. **Directed Blood Donations.**

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

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of their license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching, or any other items or services associated with, recreational activities such as: art; dance; horse riding; music; swimming; or teaching you how to play.

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

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

12. **Experimental or Investigational Services**
    a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
       i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
       ii. is the subject of a current new drug or new device application on file with the FDA; or
       iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
       iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
       v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
       vi. has not been recommended for coverage by the Interregional New Technology Committee, the Medical Technology Assessment Team, or any committees reviewing new technologies within Kaiser Permanente, based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
       vii. is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
       viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

    b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
       i. The Member's medical records; and

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

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

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

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

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

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

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

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

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

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

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

20. **Services that Are the Subject of an Out-of-Plan Provider's Notice and Consent.** Amounts owed to Out-of-Plan Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable state or federal law.

21. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.

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

23. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

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

25. **Workers' Compensation or Employer's Liability.** If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services obtained at a Kaiser facility. We will not cover any workers compensation services obtained at contracted or non-contracted providers. Any workers' compensation services provided or paid for by the health plan are subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under applicable law.

    In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers applicable law.

B. Limitations

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

C. Reductions

1. Coordination of Benefits (COB)

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

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

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

   DEFINITIONS

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

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

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

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

      When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may

be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

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

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

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

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

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

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

ORDER-OF-BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
   2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply

that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

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

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

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

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

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

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under applicable law. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

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

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

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

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

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, reduce or, in any other manner, take action that may affect our rights under this provision without our prior, written consent.

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

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

3. Surrogacy Arrangements: Traditional or Gestational Carriers

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

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

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

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

You must send this information to:

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

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

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

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

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

V. MEMBER PAYMENT RESPONSIBILITY

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

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

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

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

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

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

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

  Mailing address to submit your claim:

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

VII. GENERAL POLICY PROVISIONS

A. Access Plan

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

B. Access to Services for Foreign Language Speakers

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

C. Administration of Agreement

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

D. Advance Directives

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

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives

and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

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

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

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

E. Agreement Binding on Members

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

F. Amendment of Agreement

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

G. Applications and Statements

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

H. Assignment

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

I. Attorney Fees and Expenses

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

J. Claims Review Authority

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

K. Contracts with Plan Providers

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

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

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

L. Extra Services

In addition to the Services that we describe in this EOC, we may make available a variety of extra services. Extra services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications; and
3. Discounts for fitness club memberships

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

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

3. Participate in any required activity

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

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

Wellness Programs

You may also participate in a wellness program to incentivize healthy activities ("Wellness Program"), which enables you to earn rewards for participating in health and wellness related activities that are designed to benefit you directly either by promoting physical, mental, or emotional wellness, healthy activity, or your general wellbeing.

The Wellness Program is free to participate in and does not require you to make any payment or exchange any item of value in order to participate and earn any available rewards. However, rewards are subject to a maximum cap on the number of rewards you can receive in a calendar year. Once you reach the maximum number of total rewards for the year, completing an activity will not earn a reward, however, to encourage you to continue to engage in healthy behaviors, you will continue to receive the same number of points as the activity would have earned as a reward. Points automatically are entered as entries in promotional contests of chance, also called drawings or promotions, for each additional activity you complete.

The Wellness Program may be available only to Members enrolled through certain groups or plans.

Health Plan may engage a third party to act as the administrator of the drawings under applicable laws. This third party will ensure all details such as drawing dates, are disclosed in official rules documents that are published on our website. This third party, and not the Health Plan will be responsible for all aspects of these promotions. Additional conditions may apply to promotions, as explained by the administrator, including how to participate without internet access, including free alternate methods of entry, eligible activity periods, contact information, and winners lists. Participation in any promotion is always free, and you are never required to make any purchase or provide any consideration, or exchange any item or thing of value, if you choose to voluntarily participate.

To learn about the Wellness Program, related rewards and which ones are available to you, please check our website, *kp.org/rewards*.

Neither the Wellness Programs, nor any promotion accessible in connection with a Wellness Program, is offered as an inducement to purchase a health care plan from us.

M. Genetic Testing Information

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

N. Governing Law

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

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

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

P. No Waiver

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

Q. Nondiscrimination

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

R. Notices

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

S. Out-of-Pocket Maximum Takeover Credit

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

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

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

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

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

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

T. Overpayment Recovery

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

U. Privacy Practices

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

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

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

V. Women's Health and Cancer Rights Act

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

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

VIII. TERMINATION/NONRENEWAL/CONTINUATION

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

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

A. Termination Due to Loss of Eligibility

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

B. Termination of Group Agreement

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

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

C. Termination for Cause

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

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

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

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

D. Termination for Nonpayment

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

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

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

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

F. Rescission of Membership

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IX. APPEALS AND COMPLAINTS

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

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

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,

b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
d. uphold our previous adverse benefit determination when you appeal.

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

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

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

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

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

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

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

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

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

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

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

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

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

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

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

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

1. Pre-service claims (urgent and non-urgent)

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

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

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

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

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

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

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

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

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

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

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

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

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact **Member Services**. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

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

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

c. Urgent Pre-Service Appeal

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

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

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

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

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

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

2. Concurrent Care Claims and Appeals.

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

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

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

a. Concurrent Care Claim

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

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

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

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

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

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

b. Non-Urgent Concurrent Care Appeal

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

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact **Member Services**. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

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

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

c. Urgent Concurrent Care Appeal

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

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous

external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

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

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

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

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

3. Post-Service Claims and Appeals

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

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

a. Post-Service Claim

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

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

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

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

b. Post-Service Appeal

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

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally,

please contact Member Services. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

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

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

Voluntary Second Level of Appeal

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

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

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

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

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

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

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

Appeals of Denial of Individual Plan Application

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

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

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

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

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

External Review

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

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

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

To request external review, you must:

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

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

Expedited External Review

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

Additional Requirements for External Review regarding Experimental or Investigational Services

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

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

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

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

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

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

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

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

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

Additional Review

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

B. Complaints

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

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

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

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

X. INFORMATION ON POLICY AND RATE CHANGES

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

XI. DEFINITIONS

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

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

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

Ancillary Services: Services that are:

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

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

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

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

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For Emergency Services received from Out-of-Plan Providers (including Post Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process; or
5. For all other Services received from Out-of-Plan Providers (including Post Stabilization Services that are not Emergency Services under federal law and Ancillary Services), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the even that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Out-of-Plan Provider and us, or absent such an agreement, the usual, customary and reasonable rate for those services as determined by us based on objective criteria.
6. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

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

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

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

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

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

Doula: A trained birth companion who provides personal, nonmedical support to pregnant and postpartum people and their families prior to childbirth, during labor and delivery, during the postpartum period, and who has the qualifications and training required by the state.

Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of a person or, with respect to a pregnant person, the health of the person or their unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

- An appropriate medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Post Stabilization Care furnished by an Out-of-Plan Provider (including a nonparticipating emergency facility) is covered as Emergency Services when federal law and state law apply AND
    - Your attending Out-of-Plan Provider determines that you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider within a reasonable travel distance, taking into account your medical condition; or,
    - You (or your authorized representative) are not in a condition to receive, and/or to provide consent to, the Out-of-Plan Provider's notice and consent form, in accordance with applicable state law pertaining to informed consent as determined by your attending Out-of-Plan Provider using appropriate medical judgment.

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

Family Unit: A Subscriber and all of their Dependents.

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

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

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Premiums: Periodic membership charges paid by Group.

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

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

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

Services: Health care services or items.

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

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

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

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

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

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

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WOR0AA

ELIGIBILITY AND ENROLLMENT

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

The following paragraph of your EOC is amended, as follows:

I. ELIGIBILITY

A. Who Is Eligible

1. General

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

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

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

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

This rider amends the general eligibility provision of the EOC. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA

CHIROPRACTIC CARE

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

   You may self-refer for visits to Plan Providers.

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

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

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

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

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

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

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

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

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

   c. Durable Medical Equipment Exclusions
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost or stolen equipment.
      viii. Repairs, adjustments, or replacements necessitated by misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements.
      x. Spare equipment or alternate use equipment is not covered.

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

   b. Prosthetic Devices Exclusions
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment.

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

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

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

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-26)

PV0AD

PREVENTIVE SERVICES RIDER

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

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

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

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

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law. Additional breast imaging that is performed, either for diagnostic or supplemental purposes for members with high lifetime risk or high breast density, when recommended by your provider and within appropriate use guidelines. These Services are provided at no Charge.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.
16. Counseling, prevention, and screening for a sexually transmitted infection regardless of your gender.

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

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

RX0BL

PRESCRIPTION DRUG BENEFIT

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

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

1. Coverage

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

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

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

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

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

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

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

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin. You are not responsible for more than $100 per thirty-day supply of all covered prescription insulin drugs.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.
   e. Epinephrine auto-injectors. You are not responsible for more than $60 for all prescription two-pack epinephrine auto-injectors.

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

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs with some exceptions. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.

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

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

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

RX0BL (01-24)

THE AEROSPACE CORPORATION

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

Important plan information