2016 CU Health Plan

Benefits Booklet

Health Plan

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

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INTRODUCTION

This is not an insured benefit plan. Plan benefits are self-insured. The University of Colorado Health and Welfare Trust (the "Trust") is responsible for payment of Plan Benefits. Kaiser Permanente Insurance Company provides only administrative services on behalf of the University of Colorado Health and Welfare Plan and Trust and does not insure the Plan benefits.

The Regents of the University of Colorado (the "Plan Sponsor") and the University of Colorado Health and Welfare Trust Committee are pleased to sponsor the **CU Health Plan- Kaiser** (known in this Benefits Booklet as the "Plan") but which is a component benefit plan of the University of Colorado Health and Welfare Plan.

The Plan covers and the Trust pays for the benefits described in this Benefits Booklet. Kaiser Permanente Insurance Company (KPIC) provides administrative services for the Plan, but is not an insurer of the Plan or financially liable for Plan benefits. The Plan Sponsor self-insures the Plan. The Plan Sponsor retains exclusive and ultimate responsibility for administration of the Plan.

This Benefits Booklet describes the basic features of the Plan and contains only a summary of the key parts of the Plan and a brief description of your rights as a Participant. This Benefits Booklet is not the complete official Plan document. If there is a conflict between the Plan document and this Benefits Booklet, the Plan document will govern. A complete description of the Plan is on file at the office of the Plan Sponsor.

The Plan is an Exclusive Provider Organization plan (EPO). Therefore, you must receive all Covered Services from Network Providers, except that you can receive covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care from non-Network Providers as described in the "Emergency Services and Non-Emergency, Non-Routine Care" section.

When you enroll in the Plan, your care will be provided in one of the following Kaiser Permanente Regions: Denver/Boulder, Southern Colorado or Northern Colorado. Each Kaiser Permanente Region has its own Service Area, but you can receive Covered Services in any Region's Service Area.

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 866-213-3062
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-213-3062
CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 **866-213-3062**
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-213-3062

Plan reserves the right to amend, reduce, suspend or terminate any of the terms of the plan or coverage with a Notice of Material Modifications to enrollees not later than 60 days prior to the date on which such modification will become effective.

CUSTOMER SERVICE PHONE NUMBERS

General Member Service

Colorado Region	877-883-6698
TTY	877-870-0283

Utilization Management for Out-of Network Emergency Services

Colorado Region	303-338-3800

Advice Nurses

Colorado Region	866-311-4464

Interpreter Services

Colorado Region	877-883-6698

Pharmacy Benefit Information

Colorado	866-427-7701

Claims Administrator:

KPIC Self-Funded Claims Administrator

P.O. Box 30547

Salt Lake City, UT 84130-0547

Payor ID # 94320

DEFINITIONS

In this Benefit Booklet, Participants and Dependents may be referred to as "You /you" or "Your / your."

The following terms, when capitalized and used in any part of this Benefits Booklet mean:

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary's, eligibility to participate in the Plan;
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or service for which benefits are otherwise provided because such item or service is determined to be experimental or investigational or not Medically Necessary or appropriate.

Allowance: A dollar amount the Plan will pay for benefits for a service during a specified period of time. Amounts in excess of the Allowance are your responsibility to pay and do not apply toward your Out-of-Pocket Maximum.

Civil Union Partner: Contact your employer for eligibility requirements**.** There may be tax consequences to the Participant when enrolling his or her Partner in a Civil Union and his or her Partner's child. All references to spouse in this Benefits Booklet include a Partner to a Civil Union except a Partner in a Civil Union is not eligible for COBRA coverage. However a Partner in a Civil Union and children of a Partner are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA.

Claims Administrator: Kaiser Permanente Insurance Company. You can find the Claims Administrator's address in the "Customer Service Phone Numbers" section and on your Kaiser Permanente ID card.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accord with

recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA shall also refer to the generally parallel continuation requirements provided under the Public Health Service Act.

Coinsurance: A percentage of Eligible Charges that you must pay for certain Covered Services.

Common-Law Spouse. Contact your employer for eligibility requirements. All references to spouse in this Benefits Booklet include a Common-Law Spouse.

Community Pharmacy: A retail pharmacy under contract with Kaiser Permanente.

Copayment: A specified dollar amount that you must pay for certain Covered Services.

Cost Sharing: Copayments, Coinsurance and Deductibles.

Covered Service: Services that meet the requirements for coverage described in this Benefits Booklet.

Deductible: The amount you are required to pay for certain types of Covered Services during a plan year, before benefits will be paid.

Dental Services: Items and Services provided in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth. (Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.)

Dependent: A person who is enrolled in the Plan if the person's relationship to the Participant meets the requirements for eligibility. A dependent includes a Spouse, a Same Gender Domestic Partner and a Partner in a Civil Union. This Benefits Booklet sometimes refers to a Dependent or Participant as "you."

Durable Medical Equipment (DME): Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all of the following requirements:

- It can withstand repeated use;
- It is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of illness or injury; and
- It is appropriate for use in your home.

Eligible Charges:

- For Services provided by the Plan, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for Services provided to participants.
- For Services that Network Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge you for the item if your benefits did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs and other items, the direct and indirect costs of providing Kaiser Permanente pharmacy Services, and the pharmacy program's contribution to the net revenue requirements of the relevant Kaiser Foundation Health Plan).
- For all other Services, the amounts that the Plan pays for the Services or, if the Plan subtracts Cost Sharing from its payment, the amount the Plan would have paid if it did not subtract Cost Sharing.

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

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

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

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

Employer: University of Colorado, University of Colorado Hospital Authority and University Physicians, Inc.

Family: A Participant and all of his or her Dependents.

Hearing Aid: An electronic device you wear for the purpose of amplifying sound and assisting the physiologic process of hearing, including an ear mold if necessary.

HIPAA: Health Insurance Portability and Accountability Act of 1996, as amended.

Hospice: A specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts you may experience during the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family.

Kaiser Permanente: A Network of Providers that operate through eight Regions, each of which has a Service Area. For each Kaiser Permanente Region, Kaiser Permanente consists of Kaiser Foundation Hospitals (a California nonprofit corporation) and the **Medical Group** for that Region:

- Kaiser Foundation Health Plan, Inc., for the Northern California Region, the Southern California Region, and the Hawaii Region
- Kaiser Foundation Health Plan of Colorado for the Colorado Region
- Kaiser Foundation Health Plan of Georgia, Inc., for the Georgia Region
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., for the Mid-Atlantic States Region
- Kaiser Foundation Health Plan of the Northwest for the Northwest Region
- Kaiser Foundation Health Plan of Ohio for the Ohio Region

KPIC: Kaiser Permanente Insurance Company, which provides administrative services for the Plan.

Medically Necessary: A Service is Medically Necessary if, in the judgment of the Plan, it meets all of the following requirements:

- It is required for the prevention, diagnosis, or treatment of your medical condition;
- Omission of the Service would adversely affect your condition;
- It is provided in the least costly medically appropriate setting; and
- It is in accord with generally accepted professional standards of practice that is consistent with a standard of care in the medical community.

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

Network Provider: A Network Hospital, Physician, Pharmacy, Skilled Nursing Facility, Medical Group, or any other health care provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities please call Customer Service at the number listed in the "CUSTOMER SERVICE PHONE NUMBERS" section. To find a Kaiser Pharmacy visit **kp.org/cuhealthplan** - select the *My Health Manager* tab, select Pharmacy center.

Network Facility: Any facility listed in the provider directory which can be found by visiting **kp.org/cuhealthplan**. Note: Facilities are subject to change at any time, for the current locations, call Customer Service.

Network Hospital: A licensed hospital owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services.

Network Pharmacy: A pharmacy owned and operated by Kaiser Permanente, or another pharmacy that Kaiser Permanente designates.

Network Physician: A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services.

Network Skilled Nursing Facility: A licensed facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services that contracts with Kaiser Permanente to provide Covered Services. The facility's primary business is the provision of 24-hour-a-day skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility as long as it continues to meet the definition.

Non-Network Provider or Out-of-Network Provider: Any provider that is not a Network Provider.

Out-of-Pocket Maximum: The maximum dollar amount you can be required to pay for certain Covered Services you receive during a plan year. This amount includes Cost Sharing amounts.

Participant: Participant means the person in whose name the membership is established. This Benefits Booklet sometimes refers to a Dependent or Participant as "you."

Plan: The plan named in the "Introduction" section: CU Health Plan-Kaiser.

Plan Sponsor: The Regents of the University of Colorado.

Plan Year: The date span (Plan begin and end dates) July 1, to June 30.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your condition is Clinically Stable.

Primary Care: Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice Services.

Prior Authorization: Medical Necessity approval obtained in advance which is required for certain services to be Covered Services under the Plan. Authorization is not a guarantee of payment and will not result in payment for services that do not meet the conditions for payment by the Plan.

Prosthetics and Orthotics: An external prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Internally implanted prosthetic devices are devices placed inside the body through a surgical incision which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body part, improving the function of moveable parts or for restricting or eliminating motion in a diseased or injured part of the body.

Reconstructive Surgery: Surgery to improve function and under certain conditions, to restore normal appearance after significant disfigurement.

Region: A geographic area serviced by Kaiser Permanente**.** See "Kaiser Permanente" in this "Definitions" section.

Same Gender Domestic Partner (SGDP). Contact your employer for eligibility requirements. There may be tax consequences to the Participant when enrolling his or her SGDP and his or her SGDP's child. All references to spouse in this Benefits Booklet include a SGDP except a SGDP is not eligible for COBRA coverage. However a SGDP and children of a SGDP are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA.

Services: Healthcare, including mental health care, services and items.

Service Area: A smaller geographic area of a Kaiser Permanente Region.

Specialty Care: Care provided by a Network Provider who provides Services other than Primary Care Services.

Spouse: Your legal husband, wife or your common-law spouse. All references in this Benefits Booklet include a Partner in a Civil Union and a SGDP, except neither a Partner in a Civil Union nor a SGDP is eligible for COBRA coverage. However a SGDP/Partner in a Civil Union and children of a SGDP/Partner in a Civil Union are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA.

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

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

Plan eligibility requirements

You must meet the Plan's eligibility requirements listed below:

Service Area eligibility requirement

The Participant must live/work in a Kaiser Colorado Service Area at the time of enrollment. You cannot enroll or continue enrollment as a Participant or Dependent if you cease to live/work within a Kaiser Service Area as identified on kp.org.

Note: You may receive Urgent and Emergent care outside a Kaiser Service Area; see the Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers section for more information.

Participant

The Participant means in whose name the membership is established.

An eligible employee who has a regular work week, a Regent Board member, or special category retiree as specified in the University of Colorado Health and Welfare Plan Document is eligible to enroll for benefits as a Participant. The Participant must contact the employer for the minimum number of hours that must be worked per week and other requirements to qualify for benefits.

Dependents

A Participant's Dependents may include the following:

- **Legal Spouse.** As recognized under the laws of the state where the Participant lives.
- **Partner in a Civil Union.** All references to spouse in this Benefits Booklet include a partner in a civil union except a partner in a civil union is not eligible for COBRA coverage. There may be tax consequences to the Participant when enrolling his or her partner in a civil union and his or her partner's child. However a partner in a civil union and children of a partner in a civil union are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA. Contact your employer for eligibility requirements.
- **Common-Law Spouse**. All references to spouse in this Benefits Booklet include a Common-Law spouse. Contact your employer for eligibility requirements.

- **Same Gender Domestic Partner (SGDP).** All references to spouse in this Benefits Booklet include a SGDP except a SGDP is not eligible for COBRA coverage. There may be tax consequences to the Participant when enrolling his or her SGDP and his or her SGDP's child. However a SGDP and children of a SGDP are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA. Contact your employer for eligibility requirements.

- **Newborn child**. A newborn child born to the Participant or Participant's Spouse is covered under the Participant's membership for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Participant, the newborn is **not** provided benefits (see the "**Grandchild"** heading in this section).

  During the first 31–day period after birth, benefits for a newborn child shall consist of Medically Necessary care for injury and sickness, including well child care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures or services covered under this Benefits Booklet. All services provided during the first 31 days of coverage are subject to the Cost Sharing requirements and any benefit maximums applicable to other sicknesses, diseases and conditions otherwise covered.

  To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Participant must complete and submit a Benefits Enrollment/Change Form or online submission to the employer to add the newborn child as a Dependent child to the Participant's plan. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15^{th,} you have 31 days from the birth to notify the employer of the newborn's birth. If the current coverage is a single only plan and the child is to continue coverage beyond 31 days, the effective date of coverage for the newborn child is on the date of birth and the change in the premium payment is effective on February 1st.

- **Adopted child**. An unmarried child (who has not reached 18 years of age) adopted while the Participant or the Participant's Spouse is eligible for benefits will be covered for 31 days after the date of placement for adoption.

  "Placement for adoption" means circumstances under which a Participant assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates.

  To continue the adopted child's eligibility in the Plan beyond the 31-day period after the adopted child's placement, the Participant must complete and submit a Benefits Enrollment/Change Form or online submission to the

employer to add the adopted child as a Dependent child to the Participant's benefit Plan. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter. For example: the placement of the adopted child is on January 15th, you have 31 days from the placement to notify the employer of the adoption. If the current coverage is a single only plan and the child is to continue coverage beyond 31 days, the effective date of coverage for the adopted child is on the date of placement and the change in the premium payment is effective on February 1st.

- **Dependent child**. A Participant's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Participant for legal adoption , or a child for whom the Participant has established parental responsibility (as evidenced by court documents), or a son or daughter of a Participant's SGDP or partner in a civil union, including a legally adopted individual or an individual who is lawfully placed with the Participant's SGDP or partner in a civil union for legal adoption, or a child for whom the Participant's SGDP or partner in a civil union has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Benefits Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Participant when enrolling his or her child through the calendar month in which the child turns age 27. There may also be tax consequences to the Participant when enrolling his or her SGDP's or partner in a civil union child. A Dependent child of a Participant who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading "**Continuation of Benefits"** in this section of this Benefits Booklet The dependents (spouse or child) of a Dependent child are not eligible for coverage under this Benefits Booklet.

- **Disabled Dependent child**. An unmarried child who is 27 years of age or older, medically certified as disabled, and a Dependent of the parent may be covered under the terms of this Benefits Booklet. The employer must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 27.

- **Grandchild**. A grandchild of a Participant or a Participant's Spouse is not eligible for benefits unless the Participant or the Participant's Spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild. The Participant must submit a Benefits Enrollment/Change Form or online submission and evidence of court appointment as permanent guardian or documents evidencing a legal adoption to the employer.

Medicare-Eligible Members

Before you become age 65, or if you qualify for Medicare benefits through other circumstances, you are responsible for contacting the local Social Security Administration office to establish Medicare eligibility. You should then contact your employer to discuss your options.

For information on how the benefits will be coordinated with Medicare when coverage under this Benefits Booklet is continued, see the "Coordination of Benefits" section of this Benefits Booklet.

Enrollment Process

For eligible employees and their eligible Dependents to participate in the Plan, the Participant must follow the employer's enrollment process, which details who is eligible and what forms are required for enrollment. Eligibility for benefits under this Benefits Booklet begins as of the Effective Date as indicated in the employer's files. No services received before the date of coverage will be paid by the Plan.

You need to contact your employer at the department below for details regarding required documentation for adding a Common-Law Spouse, Civil Union Partner, SGDP.

- University of Colorado – Employee Services
- University Physicians, Inc. – Human Resources
- UCHealth – Human Resources

Note: Submission of an employer required Enrollment Change/Form or online submission to the employer does not guarantee your enrollment.

Initial Enrollment

Eligible employees may apply for benefits for themselves and their eligible Dependents by submitting a Benefits Enrollment/Change Form or online submission. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The Effective Date of eligibility for benefits will be determined in accordance with any established waiting period as determined by the employer. The employer will inform the employee of the length of the waiting period.

Open Enrollment

Any eligible employee may re-enroll during the employer's annual Open Enrollment period, which is generally a 2-3 week period before the beginning of

the Plan year. The employer will provide the Open Enrollment period date to the eligible employee.

Newly Eligible Dependent Enrollment

A current Participant of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, partnership, birth, placement for adoption or issuance of a qualified medical child support court order. The employer must receive a Benefits Enrollment/Change Form or online submission for the addition of the Dependent within 31 days after the date of the qualifying event. Eligibility for benefits will be effective on the first of the month following the qualifying event.

When the Participant or the Participant's Spouse is required by a qualified medical child support order to provide medical benefits, the eligible Dependent must be enrolled within 31 days of the issuance of such order. The employer must receive a copy of the court or administrative order with the Benefits Enrollment/Change Form or online submission.

Special Enrollment for Eligible Employees and Eligible Dependents

Special enrollment is available for eligible employees and their eligible Dependents who currently are not enrolled in the employer benefit plan. Special enrollment is allowed when a family status change occurs or when an involuntary loss of coverage occurs.

Family Status Change

Qualifying events for special enrollment due to a family status change include marriage, partnership, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Benefits under this Plan will be effective on the date of the qualifying event or the first of the month following the qualifying event, depending on the nature of the qualifying event. When the qualifying event is a birth, and the mother is not previously enrolled, any charges related to labor and delivery due to the birth are not covered. The employer must receive the completed Benefits Enrollment/Change Form or online submission within 31 days after the date of the qualifying event. Proof of the qualifying event may be required by the employer.

Involuntary Loss of Coverage

For the eligible employee and/or eligible Dependent to qualify for special enrollment due to involuntary loss of the other group health insurance coverage, the loss of coverage must be due to termination of employment, reduction in the number of hours of employment, involuntary termination of creditable coverage, death of an employee, legal separation or divorce, cessation of dependent status, the other plan no longer offering any benefits to the class of individuals, or the termination of employer contributions toward the coverage. If the employee is approved for special enrollment, coverage will be effective on the day following

the loss of other coverage. If COBRA/continuation coverage is available, enrollment may only be requested after exhausting the COBRA/continuation coverage.

If the eligible employee and/or the eligible Dependents had health insurance coverage elsewhere and voluntarily canceled such coverage, the eligible employee and/or the eligible Dependents do not qualify for special enrollment. However, the eligible employee and/or the eligible Dependents will be allowed to enroll at the employer's annual Open Enrollment period.

Status Change of State Medicaid Plan or State Child Health Insurance Program (SCHIP)

Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for the eligible employee and/or eligible Dependents. The employee must properly file an application with the employer within 60 days after coverage has ended. In addition, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Special enrollment due to court or administrative order.

Within 31 days after the date of a court or administrative order requiring a Participant to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent.

Your Employer will determine the effective date of an enrollment resulting from a court or administrative order, except that the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

Special enrollment due to a Section 125 qualifying event.

You may enroll along with any eligible Dependents and existing Participants may add eligible Dependents, if you experience an event that your Employer designates as a special enrollment qualifying event.

Military Service

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to employees and their Dependents covered under the Plan before the employee leaves for military service Benefits under USERRA continuation of coverage shall end on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

How to Change Coverage

If your employer provides you with multiple health care options, eligible employees may switch coverage for themselves and/or their eligible Dependents to another benefit Plan offered by the University of Colorado Health and Welfare Plan during Open Enrollment.

Termination

Your benefits end on the first occurrence of one of the following events:

- On the date the Plan described in this Benefits Booklet is terminated.
- Upon the Participant's death.
- When the required benefit contribution or administrative fee have not been paid.
- When you commit fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for benefits under the terms of this Benefits Booklet.
- When your employer gives Kaiser Permanente notice that the Participant is no longer eligible for benefits. Benefits will be terminated as determined by your employer. The Trust reserves the right to recoup any benefit payments made for dates of service after the termination date.
- When Kaiser Permanente receives notification to cancel coverage for any Participant, benefits will end at the end of the month following notification or at the end of the month of the qualifying event.
- When you move and therefore no longer reside within the service area, you must notify your employer within 31 days of such a change in location. Coverage will end on the last day of the month in which the change of residence is reported; until that time, the only out-of-area services covered will be Emergency care and Urgent care. Non-Emergency care will not be covered.

- If you do not notify your employer of a change of residence to an area outside the Denver/Boulder, Northern Colorado or Southern Colorado Service Areas, and Kaiser Permanente or Your Employer later becomes aware of the change, your benefits may be retroactively terminated to the date of the change of residence. You will be liable to the Trust and/or the Providers for payment for any services covered in error.
- For Cause - Upon written notice to the Participant, the eligibility of the Participant and his or her Dependents may be immediately terminated if the Participant or Dependent(s):

  (1) Threaten(s) the safety of Administrator or Provider personnel or any person or property at a Network Facility.
  (2) Commit(s) theft from the Administrator or Network Provider or at a Network Facility.
  (3) Perform(s) an act that constitutes fraud, or make(s) an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an invalid prescription or physician order, or (3) misusing or letting someone else misuse a KPIC card or Medical Record Number to obtain care under false pretenses. Note: Any Participant's or Dependent's fraud will be reported to the authorities for prosecution and appropriate civil remedies will be pursued.

  Termination will be effective on the date notice is sent. All rights cease as of the date of termination.
- When Kaiser Permanente ceases operations.

Dependent Coverage Termination

To remove a Dependent from the Plan, the Participant must complete a Benefits Enrollment/Change Form or online submission and submit it to the employer. The change will be effective at the end of the month Kaiser Permanente is notified of the change. The Trust reserves the right to recoup any benefit payments made after the termination date.

Benefits for a Dependent end on the last day of the month for the following qualifying events:

- When the Participant or the employer notifies Kaiser Permanente in writing to cancel benefits for a Dependent.
- When the Dependent child no longer qualifies as a Dependent by definition. Such a Dependent has the right to elect COBRA /continuation coverage.

- On the date of a final divorce decree or legal separation for a Dependent Spouse. Such a Dependent has the right to elect COBRA /continuation coverage.
- When legal custody of a child placed for adoption is terminated.
- Death of the Dependent.

What The Trust Will Pay for After Termination

Except as provided below, Kaiser Permanente, on behalf of the Trust, will not authorize payment for any services provided after your benefits end even if Services were preauthorized, unless prohibited by law. Benefits cease on the date your participation ends as described above. You may be responsible for benefit payments authorized by Kaiser Permanente on your behalf for services provided after your benefits have been terminated.

Kaiser Permanente does **not** cover services received after your date of termination even if:

- Kaiser Permanente preauthorized the service; and/or
- The services were made necessary by an accident, illness or other event that occurred while benefits were in effect.

HOW TO OBTAIN SERVICES

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

- o "Emergency Services and Non-Emergency, Non-Routine Care" section
- o "Getting a Referral," section

The Kaiser Permanente medical care program gives you access to all of the Covered Services you may need, such as routine care with your own personal Network Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the "Benefits and Cost Sharing" section.

Routine Care

Routine appointments are for medical needs that are not urgent, such as routine preventive care. Try to make your routine care appointments as far in advance as possible.

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number (see the "CUSTOMER SERVICE PHONE NUMBERS" section listed on the first page of this Benefits Booklet after the Table of Contents). Note: Urgent Care received in a Kaiser Permanente Region from a Non-Network emergency department is not covered.

Advice Nurses

Sometimes it's difficult to know what type of care you need. That's why Kaiser Permanente has telephone advice nurses available to assist you. These advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell you what to do if a Network Provider is closed, or advise you about what to do next, including making a same-day appointment for you if it's medically appropriate. To reach an advice nurse, please call the advice nurse phone number listed in the "CUSTOMER SERVICE PHONE NUMBERS" section this Benefits Booklet.

Your Personal Network Physician

Personal Network Physicians provide Primary Care and play an important role in coordinating care, including hospital stays and referrals to specialists. For the current list of physicians who are available as Personal Network Physicians, and to find out how to select a Personal Network Physician, please call customer service at the number listed in the "CUSTOMER SERVICE PHONE NUMBERS" section of this Benefits Booklet or visit kp.org/cuhealthplan, by clicking on clinical staff directory under the "Get Started Now" heading, select your region, select HMO and then select Colorado Kaiser Permanente (CPMG) practitioners. You can change your Personal Network Physician for any reason. Every member of your family should have his or her own primary care Personal Network Physician (PCP).

Telemedicine

Interactive video visits between you and your Personal Network Physician are intended to make it more convenient for you to receive medically appropriate Covered Services. When available, you may receive Covered Services listed under the Benefits and Cost Sharing section via interactive video visits, subject to the "General Limitations, Coordination of Benefits, and Reductions" section. You are not required to use interactive video visits. If you do agree to use interactive video visits, Cost Sharing may apply for the services you receive (e.g., Primary Care or Specialist Cost Share).

Referrals

You are required to obtain a referral from your Network physician prior to receiving specialty care services under the Plan. If you receive specialty care services for which you did not obtain a referral, you will be responsible for all the charges associated with those services.

Self Referrals

You do not need a referral or prior authorization to receive care from any of the following:

- Your personal Network Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, psychiatry, chemical dependency
- Obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology
- Chiropractic and Acupuncture services

Although a referral or prior authorization is not required to receive care from these providers, the provider may have to get prior authorization for certain Services.

Additionally some regions allow self-referral to certain specialties:

Colorado Region

- Denver/Boulder Service Area
  You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department, laboratory, and radiology and for specialty procedures such as a CT scan, MRI, colonoscopy or surgery.
- Northern and Southern Colorado Service Areas
  You may self-refer for consultation (routine office) visits to Network Physician specialty-care providers identified as eligible to receive direct referrals in the Provider Directory www.kp.org, click “Locate our services” then “Medical staff directory.” You can obtain a paper copy of the directory by calling Member Services toll-free at 1-888-681-7878 or TTY 1-800-521-4874.

A self-referral provides coverage for routine visits only. Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Network Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Network Physicians. Medical Group physicians in the Denver/Boulder Service Area will not be eligible for self-referrals. Services other than routine office visits with a Network Physician specialty-care

provider eligible to receive self-referrals will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Getting a Referral

Referrals

A written or verbal recommendation by a Network Physician that you obtain non-covered Services (whether Medically Necessary or not) is not considered a referral and is not covered.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance. You will receive a copy of the written referral when it is approved. The Trust will not pay for any care rendered or recommended by a non-Network Physician beyond the limits of the original referral unless the care is specifically authorized by your Network Physician and approved in advance.

Prior Authorizations

Certain Services require Prior Authorization in order for the Plan to cover them. Your Network Physician will request Prior Authorization when it is required, except that you must request Prior Authorization in order to receive covered Post-Stabilization Care from Non-Network Providers.

Prior Authorization is required for Services provided by: (i) non-Network Providers or non-Network Facilities and (ii) Services provided by any provider outside your Service Area. Authorization may be required for Services performed in any facility other than the physician's office. A referral for these Services will be submitted by the Network Physician. You will be notified of the determination regarding Authorization for coverage.

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

Required Prior-Authorization List

- All inpatient and outpatient facility services (excluding emergencies)
- Office based habilitative /rehabilitative: Occupational; Speech, and Physical therapies.
- All services provided outside a KP facility
- All services provided by non-network providers
- Drugs and Durable Medical Equipment not contained on the KP formulary

Second Opinions

Upon request and subject to payment of any applicable Copayments or Coinsurance, you may obtain a second opinion from:

- A Network Physician about any proposed Covered Services or
- A Non-Network Provider with Prior Authorization.

Network Facilities

At most Network Facilities, you can usually receive all the Covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Network Facility within your selected sub region, and you are encouraged to use the Network Facility that will be most convenient for you:

- All Network Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Network Hospital Emergency Departments (please refer to **kp.org/cuhealthplan** for Emergency Department locations in your area)
- Same-day appointments are available at many locations (please refer to **kp.org/cuhealthplan** for Urgent Care locations in your area)
- Many Network Facilities have evening and weekend appointments
- Many Network Facilities have a customer services department (refer to **kp.org/cuhealthplan** for locations in your area)

Network Facilities for your area are listed in greater detail on kp.org, which details the types of Covered Services that are available from each Network Facility in your area because some Network Facilities provide only specific types of Covered Services. It explains how to make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice

Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers

This section explains how to obtain covered emergency, post-stabilization, and out of area Urgent Care from non–Network Providers. The Non–Network Provider care discussed in this section is not covered unless it meets both of the following requirements:

- This "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section says the care is covered.
- The care would be covered if you received the care from a Network Provider

For example, non-Network Skilled Nursing Facility care is not covered as part of authorized Post-Stabilization Care unless both of the following are true:

- Kaiser Permanente authorizes the care and the care meets the definition of "Post-Stabilization Care"
- The care would be covered if you received the care from a Network Skilled Nursing Facility inside the Service Area

You do not need to get Prior Authorization from Kaiser Permanente to get Emergency Services or Urgent Care outside the Service Area from non–Network Providers. However, you (or someone on your behalf) must get Prior Authorization from Kaiser Permanente to get covered Post-Stabilization Care from Non–Network Providers.

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Network Providers or Non-Network Providers anywhere in the world, as long as the Services would have been covered under the “Benefits and Cost Sharing” section (subject to the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section) if you had received them from Network Providers.

Emergency Services are available from Hospital emergency departments 24 hours a day, seven days a week.

For ease and continuity of care, you are encouraged to go to a Network Hospital emergency department if you are inside the Service Area, but only if it is reasonable to do so, considering your condition or symptoms. If you have been admitted to a Non Network hospital, your stay will be covered if Kaiser Permanente is notified within 24hours or as soon as reasonably possible of stabilization of your condition..

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care received from a Non–Network Provider, including inpatient care at a non–Network Hospital, is covered only if Kaiser Permanente provides Prior Authorization for the care.

To request prior authorization to receive Post-Stabilization Care from a Non–Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as

reasonably possible). A Kaiser Permanente representative will then discuss your condition with the Non–Network Provider. If Kaiser Permanente decides that you require Post-Stabilization Care and that this care would be covered if you received it from a Network Provider, they will authorize your care from the Non–Network Provider or arrange to have a Network Provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a Network Hospital, Network Skilled Nursing Facility, or designated Non–Network Provider provide your care, they may authorize special transportation services that are medically required to get you to the provider. If this occurs, then those special transportation services will be covered, even if they would not be covered under "Ambulance Services" in the "Benefits and Cost Sharing" section if a Network Provider had provided them.

Be sure to ask the Non–Network Provider to tell you what care (including any transportation) Kaiser Permanente has authorized, because unauthorized Post-Stabilization Care or related transportation provided by Non–Network Providers is not covered.

Sometimes extraordinary circumstances can delay your ability to call Kaiser Permanente to request authorization for Post-Stabilization Care from a Non–Network Provider (for example, if you are unconscious, or if you are a young child without a parent or guardian present). In these cases, you (or someone on your behalf) must call Kaiser Permanente as soon as reasonably possible.

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number (see the "CUSTOMER SERVICE PHONE NUMBERS" section listed on the first page of this Benefits Booklet after the Table of Contents). Note: Urgent Care received in a Kaiser Permanente Region from a Non-Network emergency department is not covered.

Out-of-Area Urgent Care

If you need prompt medical care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), your Plan covers Medically Necessary Services that you receive from a Non–Network Provider outside the Service Area to prevent serious deterioration of your (or your unborn child's) health if all of the following are true:

- You receive the Services from Non–Network Providers while you are temporarily outside the Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to the Service Area

Services Not Covered Under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" Section

The following Services are not covered under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section (instead, refer to the "Benefits and Cost Sharing" section):

- Services that are not Emergency Services, Post-Stabilization Care, or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition.
- Emergency Services, Post-Stabilization Care, and Urgent Care that you receive from Network Providers

Out-of-Network Non-Emergency, Non-Routine Care

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

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

Payment

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

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

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

Our payment is reduced by:

- the Copayment and/or Coinsurance for Emergency Services and Special Procedures performed in the emergency room. The emergency room and Special Procedures Copayment, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
- the Copayment or Coinsurance for ambulance Services, if any; and
- Coordination of benefits; and

- any other payments you would have had to make if you received the same Services from our Network Providers; and
- all amounts paid or payable, or which in the absence of this Plan 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
- amounts you or your legal representative recover(s) from motor vehicle insurance or because of third party liability.

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

Out-of-Area Student Benefit

A limited benefit is available to Dependents who are full-time students attending an accredited college, vocational or boarding school outside the Denver/Boulder, Northern Colorado or Southern Colorado Service Area. The out-of-area student benefit applies to Services listed in the Summary Chart. The Plan will pay a percentage of Charges for eligible Services, and the Participant is responsible for paying the remaining amount.

To qualify for the out-of-area student benefit, the Dependent must meet the eligibility requirements of the Plan and carry at least 12 credit hours per term. Verification of student status will be necessary. For more information, Denver/Boulder, Northern Colorado and Southern Colorado Participants, please call Customer Service.

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

Moving Outside of the Service Area

If you move to an area not within the Denver/Boulder, Northern Colorado or Southern Colorado Service Area you will be required to change your health plan to one that services your area. Please contact your employer for instruction.

Getting Assistance

Kaiser Permanente wants you to be satisfied with the health care you receive. If you have any questions or concerns about the care you are receiving, please discuss them with your personal Network Physician or with any other Network Providers who are treating you. They want to help you with your questions. You

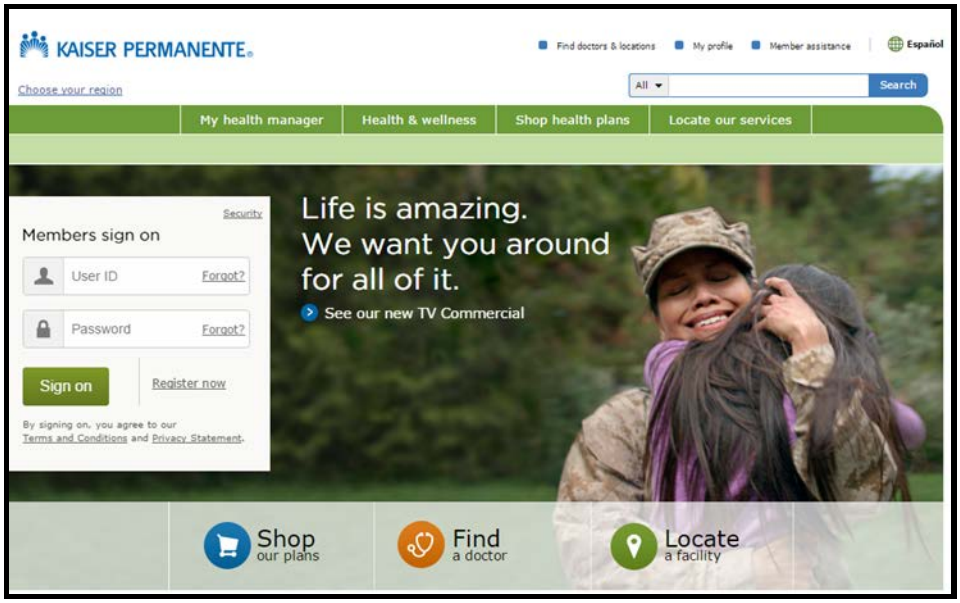
may also call customer service at the number listed in the "CUSTOMER SERVICE PHONE NUMBERS" section.

Using Your KPIC Identification Card

Each Participant is issued a KPIC (ID) card with a Health Record Number on it, which is useful when you call for advice, make an appointment, or go to a Network Provider for care. The Health Record Number is used to identify your medical records and Plan information. You should always have the same Health Record Number. If you are ever inadvertently issued more than one Health Record Number, please let us know. Please call Customer Service. If you need to replace your Health Plan ID card, please call Customer Service in your area.

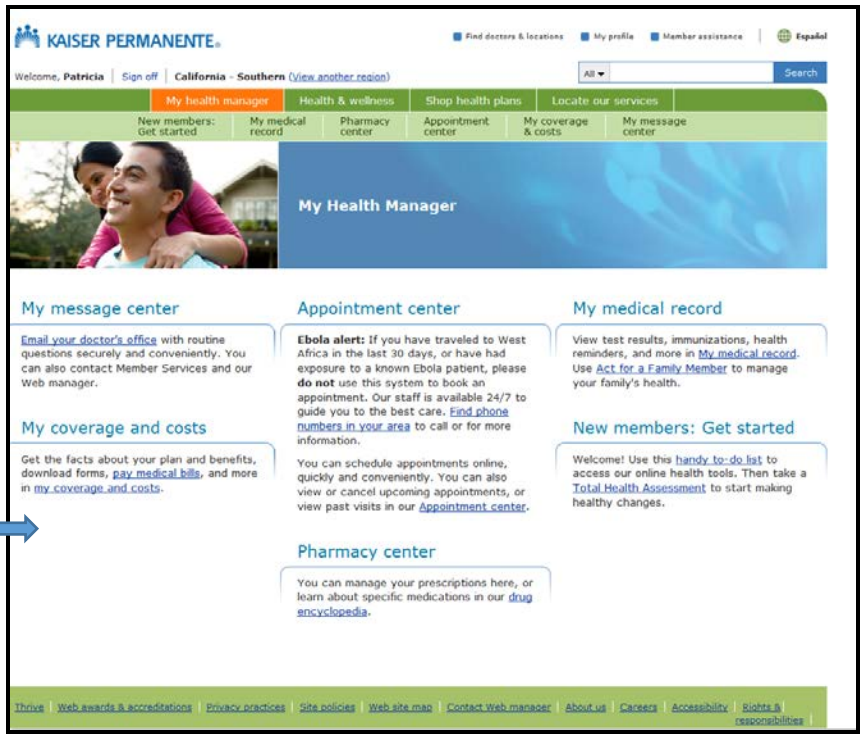
Anyone who is not a Participant will be billed as a non-Participant for any Services the Plan provides and claims for Emergency or non-emergency care Services from non-Network Providers will be denied. If you let someone else use your KPIC ID card, the Network Facility may keep your card and terminate your participation in the Plan.

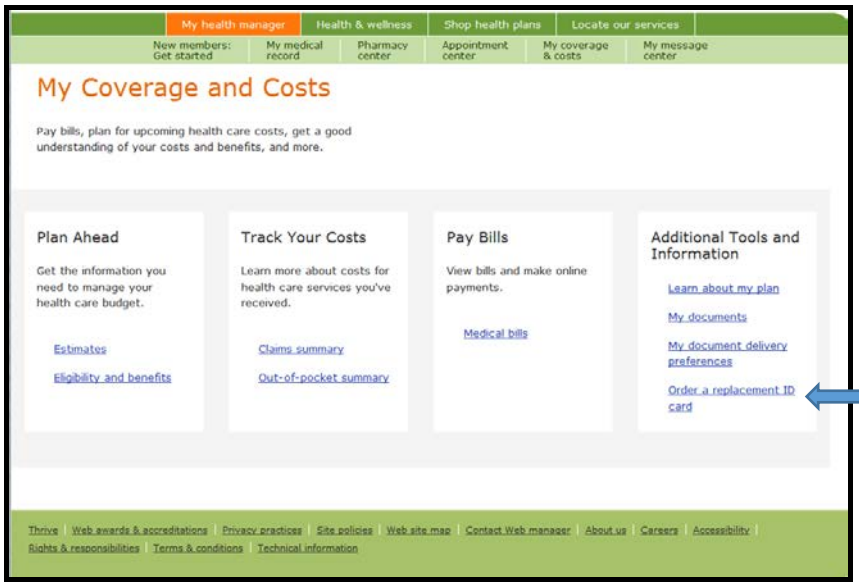
When you receive Services, you will need to show photo identification along with your KPIC ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership has been victimized by fraud, please call Customer Service to report your concern.



To print a temporary card or replace your Kaiser Permanente ID card, call Customer Service at the number listed in "CUSTOMER SERVICE PHONE NUMBERS" section of log onto kp.org

Choose the *My Coverage and Costs* Services drop-down menu.





Then select the link to *Order a replacement ID card*. From this link you can print a temporary card and order new cards.

Your ID card is for identification only. In order for the Plan to cover Services, you must be a current Participant or Dependent on the date you receive the Services. Anyone who is not a Participant or Dependent will be billed for any Services he or she receives, and the amount billed may be different from the Eligible Charges for the Services.

Receiving Care in Other Kaiser Permanente Regions

You will probably receive most Covered Services in the Service Area of the Kaiser Permanente Region where you live or work. If you are in the Service Area of another Kaiser Permanente Region, you may receive Services from Network Providers in that Region, though Services that require a referral or Prior Authorization may differ among Regions. For information about Network Providers or Services in another Region, please call customer service for that Region at the number listed in the "Customer Service Phone Numbers" section.

Interpreter services

If you need interpreter services when you call or when you get Covered Services, please let Kaiser Permanente know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you, at Network Facilities. For more information, please call Customer Service.

BENEFITS AND COST SHARING

The only Services that are covered under this Plan are those that this "Benefits and Cost Sharing" section says that are covered, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the "General Exclusions and Limitations" section. Exclusions and limitations that apply only to a particular benefit are described in this "Benefits and Cost Sharing" section. Exclusions, limitations, coordination of benefits, and reductions that apply to all benefits are described in the "General Exclusions and Limitations" section.

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

- You are a Participant or Dependent on the date that you receive the Services,
- A Network Physician determines that the Services are Medically Necessary,
- The Services are provided, prescribed, Authorized, or directed by a Network Physician except where specifically noted to the contrary in the "Emergency Services and Non-Emergency, Non-Routine Care" section.
- You receive the Services from Network Providers inside the Service Area except where specifically noted to the contrary in the following sections for the following Services:
    - Authorized referrals as described under "Getting a Referral" section in the "HOW TO OBTAIN SERVICES" section
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Non-Emergency, Non-Routine Care" section.

- Emergency ambulance Service as described under "Emergency Services and Non-Emergency, Non-Routine Care " section.

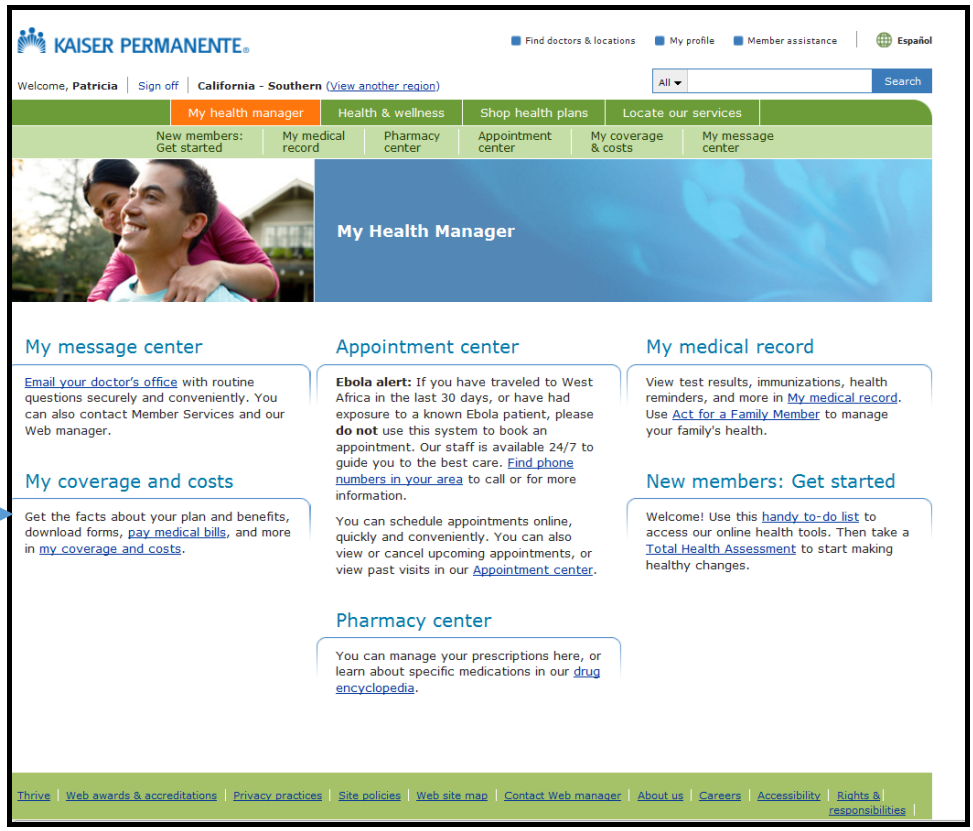
Medical necessity

A Kaiser Permanente health professional will determine if services are medically necessary for each member. A service is considered medically necessary if it's medically required to prevent, diagnose, or treat a member's condition or clinical symptoms and it's consistent with generally accepted professional standards of care in the medical community.

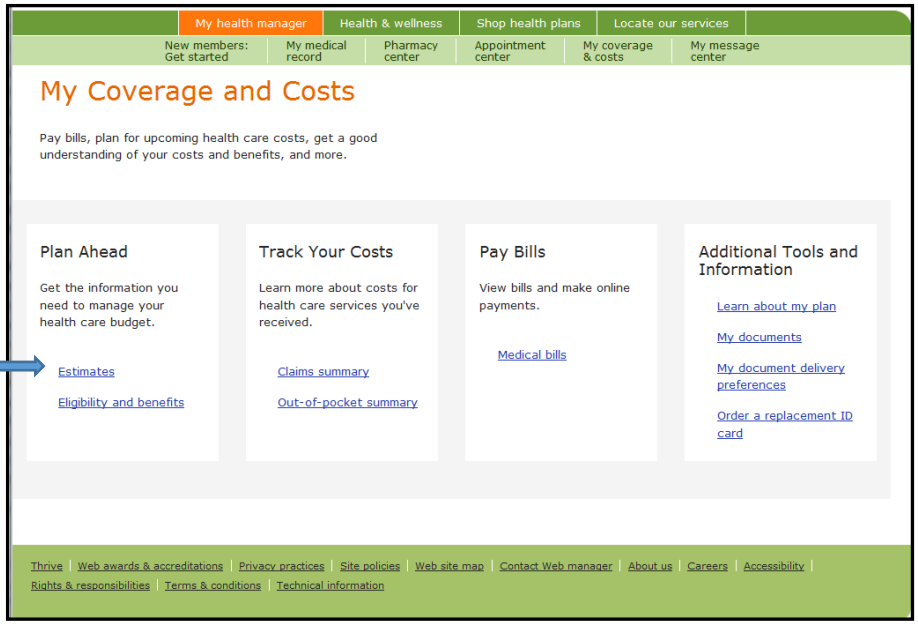
Cost Sharing (Copayments and Coinsurance)

The "Summary Chart" describes the Cost Sharing you must pay for Covered Services. Cost Sharing is due at the time you receive the Services. For items ordered in advance, you pay the Cost Sharing in effect on the order date (although the item will not be covered unless you still have coverage for it on the date you receive it). Unless specified otherwise, when services can be provided in different settings, the Cost Sharing is applied according to the place of service in which the care is delivered and according to the type of provider providing the service. For example: if the service is provided during a hospital admission, the Inpatient Hospital Services Cost Sharing is applied. If the same service is performed in an office setting by a specialist, the specialty care office visit Cost Sharing is applied.

To estimate your cost sharing and plan your medical expenses go to www.Kp.org then select *My coverage and costs.*



On this page select *Estimates*



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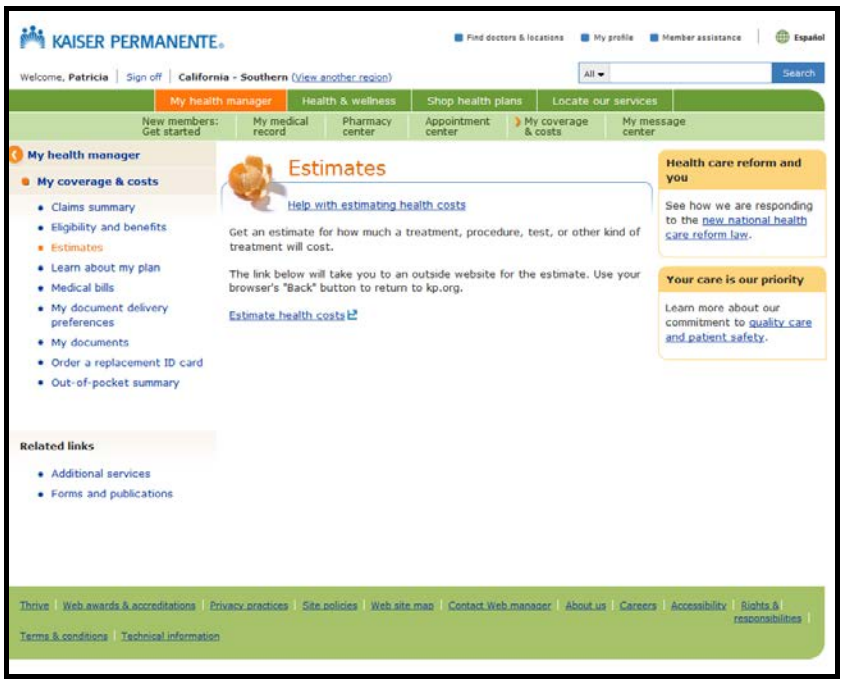


From this page you will be taken to an external estimation tool and logged out of Kp.org.

Benefit Maximums and Benefit Limits

The "Summary Chart" describes dollar limits, Benefit or Plan Maximum Benefit Allowances and any day, visit or quantity limits applicable to Covered Services.

Plan year Out-Of-Pocket Maximums

There are limits to the total amount of Cost Sharing you must pay in a plan year for certain Covered Services that you receive in the same plan year. Those limits can be found in the "Summary Chart".

If you are part of a Family that includes at least two people (counting the Participant and any Dependents), you reach the plan year out-of-pocket maximum when you meet the maximum per Participant or Dependent, or when your Family meets the maximum for a Family (whichever happens first).

After you reach the plan year out-of-pocket maximum, you do not have to pay any more Cost Sharing for Service subject to the plan year out-of-pocket maximum through the end of the plan year. You will continue to pay Cost Sharing for Covered Services that do not apply to the plan year out-of-pocket maximum.

For the plan year out-of-pocket maximum by benefit, please refer to the "Summary Chart" in this Benefits Booklet.

Outpatient Services

The following outpatient care is covered for Services to diagnose or treat an injury or disease:

- Primary care visits: Services from family medicine, internal medicine, and pediatrics.
- Specialty care visits: Services from providers that are not primary care, as defined above.
- Acupuncture.
- Bariatric Surgery - you must meet the certain criteria to be eligible for coverage.
- Chiropractic care.
- Allergy consultations, testing and treatment.
- Biofeedback.
- Blood and blood products and their administration.
- Chemotherapy.
- Diagnostic x-rays and lab test and other diagnostic tests such as EEGs / EKGs performed during an office visit.
- Drugs that require administration or observation by medical personnel. Consultations with clinical pharmacists (at Kaiser Permanente Pharmacies Only).
- House calls by a Network Physician when care can best be provided in your home.
- Infusion Services provided in an outpatient setting.
- Injections (except preventive immunizations).
- Medical supplies used during an outpatient visit.
- Medically necessary surgical or non-surgical treatment of temporomandibular joint (TMJ) dysfunction. Dental treatment of TMJ is not covered.
- Maternity - Pre-natal and post-partum visits.
- Outpatient surgery including FDA approved internally implanted prosthetic devices such as breast implants following a covered mastectomy.
- Preventive care Services (see “Preventive Care Services” in this “Benefits and Cost Sharing” section for more details).
- Radiation therapy.
- Respiratory therapy.
- Surgical procedure performed in the office.

Hospital Inpatient Care

The following inpatient Services are covered:

1) Room and board, such as semiprivate accommodations or, when a Network Physician determines it is Medically Necessary, private accommodations or private duty nursing care.
2) Intensive care and related hospital Services.
3) Professional Services of physicians and other health care professionals during a hospital stay.
4) General nursing care.

5) Obstetrical care and delivery (including Cesarean section). Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Network Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. Well newborn charges are treated as part of the mother's bill. Sick newborns are subject to all Plan provisions including his/her own Copayment and Coinsurance requirements.
6) Meals and special diets.
7) Other hospital Services and supplies, such as:
    a. Operating, recovery, maternity and other treatment rooms.
    b. Prescribed drugs and medicines.
    c. Diagnostic laboratory tests and X-rays.
    d. Blood, blood products and their administration.
    e. Dressings, splints, casts and sterile tray Services.
    f. Anesthetics, including nurse anesthetist Services.
    g. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.
8) Bariatric Surgery - you must meet the Plan criteria to be eligible for coverage.

Hospital Inpatient Care Exclusions:

1) Dental Services are excluded, except that the Plan covers hospitalization and general anesthesia for dental Services provided to Participant as defined by the Plan.
2) Travel/lodging and Cosmetic surgery related to bariatric surgery.

Acupuncture Services

See Chiropractic and Acupuncture Services below.

Ambulance Services

The Plan covers ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

Ambulance Services Exclusion:

Transportation by car, taxi, bus, gurney van, minivan and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Network Provider.

Chemical Dependency Services

Inpatient Medical and Hospital Services

The Plan covers Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

Residential Rehabilitation

The determination of the need for services of a residential rehabilitation program under this benefit, and referral to such a facility or program, is made by or under the supervision of a Network Physician.

The Plan covers inpatient services and partial hospitalization in a residential rehabilitation program approved by the Plan for treatment of alcoholism, drug abuse or drug addiction.

Outpatient Services

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

Mental Health Services required in connection with treatment for chemical dependency are covered as provided in the "Mental Health Services" section below.

Participants who are disruptive or abusive maybe terminated for cause from this Plan

Chemical Dependency Services Exclusion:

Counseling for a patient who is not responsive to therapeutic management, as determined by a Network Physician.

Chiropractic and Acupuncture Services

Coverage includes evaluation, laboratory Services and X-rays required for chiropractic Services, and treatment of musculoskeletal disorders. You may self-refer for covered visits to participating chiropractors.

Acupuncture and Acupressure services for pain relief and normalization of physiologic functions are covered. Services include passing long, thin needles through the skin to specific points and application of pressure at acupuncture sites.

Exclusions:

Any treatment or Services delivered by a participating chiropractor or his or her employee, determined not to be chiropractically necessary by a participating chiropractor, or Services in excess of the benefit maximum; treatment or Services for pre-employment physicals; hypnotherapy, behavior training, sleep therapy or weight loss programs; laboratory tests, X-rays or other treatment classified as experimental or in the research stage that have not been documented as chiropractically necessary or appropriate; Services not related to the examination and/or treatment of the musculoskeletal system; vocational rehabilitation Services; thermography; air conditioners, air purifiers, therapeutic

mattresses, supplies, or any other similar devices and appliances; transportation costs including local ambulance charges; prescription drugs, vitamins, minerals, nutritional supplements or other similar-type products; educational programs; non-medical self-care, or self-help training; any or all diagnostic testing related to these excluded Services; MRI and/or other types of diagnostic radiology; physical or massage therapy that is not a part of the chiropractic treatment; and durable medical equipment (DME) and/or supplies for use in the home.

To Locate a Network Provider Contact:

Colorado Region Columbine Chiropractic
303-893-1900
(no acupuncture network–utilize any willing provider)

Exclusions:
The following services are not covered:

- Chiropractic services for conditions other than Neuromusculoskeletal Disorders,
- Behavior training and sleep therapy,
- Thermography,
- Any radiologic exam, other than plain film studies, such as magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), bone scans and nuclear radiology,
- Non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing,
- Services for vocational rehabilitation,
- Air conditioners, air purifiers, therapeutic mattresses; chiropractic appliances, supplies and devices.
- Hospital Services, anesthesia, manipulation under anesthesia, and related Services
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations, Vitamins, minerals, nutritional supplements, and similar products

Clinical Trials

In-Network and referred Non-Network Services for an Approved Clinical Trial are covered for Qualified Individuals to the extent services identified in the "Schedule of Benefits" are covered outside an Approved Clinical Trial.

"Qualified Individual" means an enrollee who is eligible to participate in an Approved 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:

- The referring provider is a Network provider who has made this determination.
- The patient provides medical and scientific information establishing this determination.

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and that meets one of the following requirements:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by at least one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - 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 HHS Secretary 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.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Exclusions:

- Non-Approved Clinical Trials
- Investigational items or services.
- Items and services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient.
- Services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis.

Dialysis Care

The Plan covers dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1) The Services are provided inside our Service Area; and
2) You satisfy all medical criteria; and
3) The facility is certified by Medicare and is a Network Facility; and
4) A Network Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, the Plan covers equipment, training and medical supplies required for home dialysis at no Charge.

Drugs, Supplies and Supplements

The Plan uses a drug formulary. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees. Our committees, which are comprised of Network Physicians, pharmacists and a nurse practitioner, select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, please call Member Services at 877-883-6698 or TTY at 877-870-0283.

PRESCRIPTION DRUG BENEFIT

NOTE: When the Plan uses the term "preferred" it refers to drugs that are included on the Formularies and the term "non-preferred" refers to drugs that are not included in the Formularies.

Please refer to the "Summary Chart" in this Benefits Booklet for the specific Copayments, Coinsurance, and supply limits that may apply to the covered prescription drugs described below.

Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage which includes a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; and a tier for prescribed non-preferred drugs that have been Authorized through the non-preferred drug process.

Prescribed supplies and accessories include, but may not be limited to, home glucose monitoring supplies, glucose test strips, acetone test tablets, nitrate urine test strips for pediatric patients, and disposable syringes for the administration of insulin. Such items are provided at the Copayment or Coinsurance shown and at the day supply per item when obtained at Network Pharmacies.

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Coinsurance up to the maximum amount per drug dispensed.

The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Certain drugs that have a significant potential for waste and diversion will be provided for up to a 30-day supply at the applicable prescription drug Copayment or Coinsurance. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Participant for any prescribed amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

The 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 that are not listed as generic in the then-current commercially available drug database(s) are provided at the brand name Copayment and the day supply for maintenance drugs or up to the day supply for non-maintenance drugs.

If requested, refills will be mailed up to the mail-order day supply and at the applicable Copayment or Coinsurance through Kaiser Permanente's mail-order prescription service. Certain drugs that have a significant potential for waste and diversion are not available by mail-order service. Refills will be mailed by First-Class U.S. Mail with no charge for postage and handling. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact Member Services at 877-883-6698 or TTY at 877-870-0283.

The following drugs are covered only when prescribed by a Network Physician, a physician to whom a Participant has been referred by a Network Physician, or a dentist (when prescribed for acute conditions), and obtained at Network Pharmacies:

a. Drugs for which a prescription is required by law. Network Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Network Physician. If a Participant requests a brand-name drug when a generic equivalent drug is the preferred product, the Participant must pay the brand-name Copayment, plus any difference in price between the preferred generic equivalent drug prescribed or authorized by the Network Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, the Member pays only the brand-name Copayment.

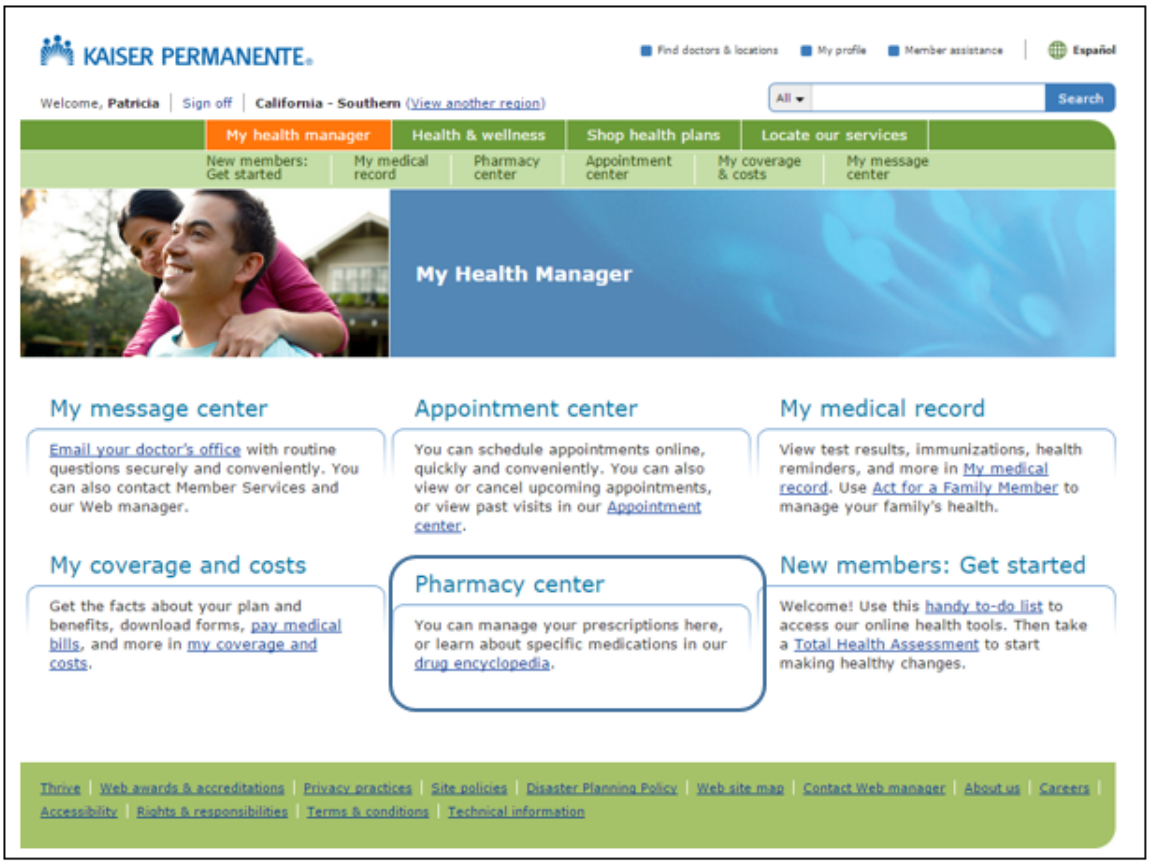
b. Insulin

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

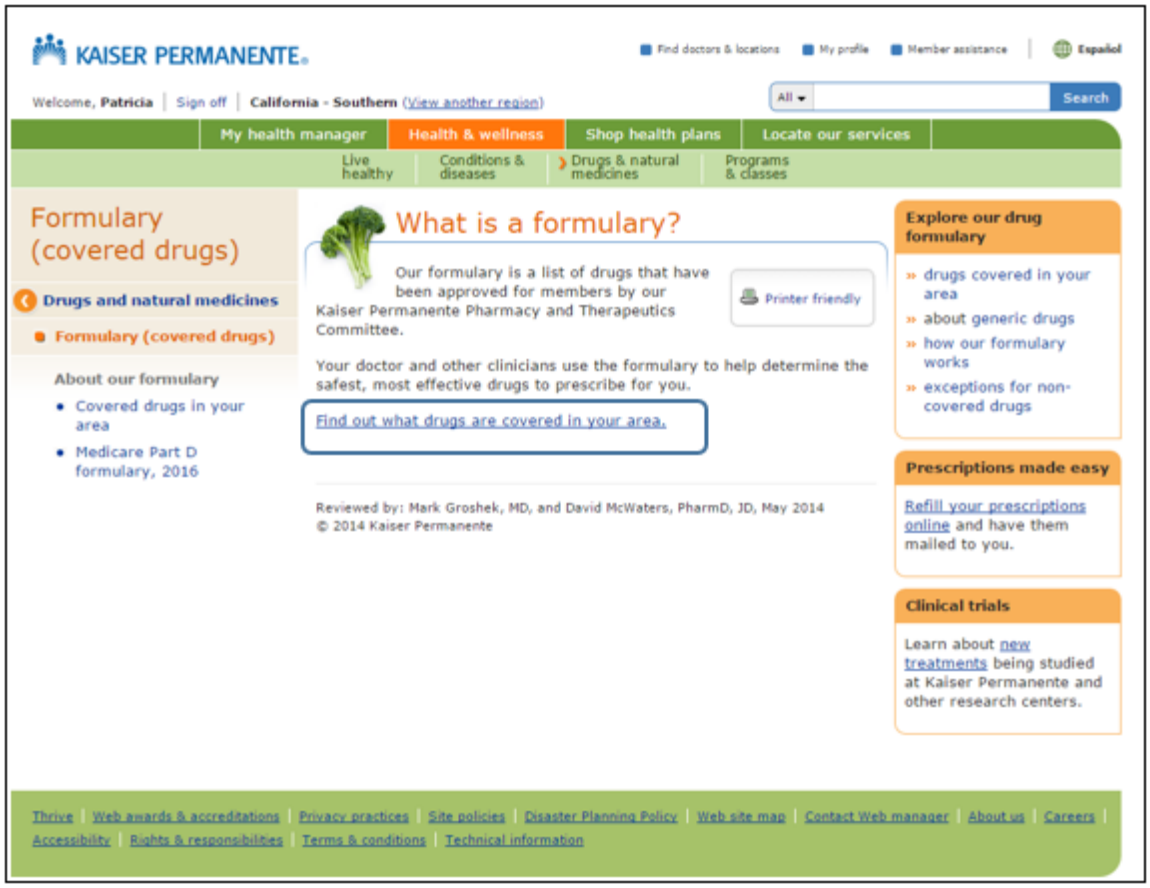
Drugs, Supplies and Supplements Exclusions:

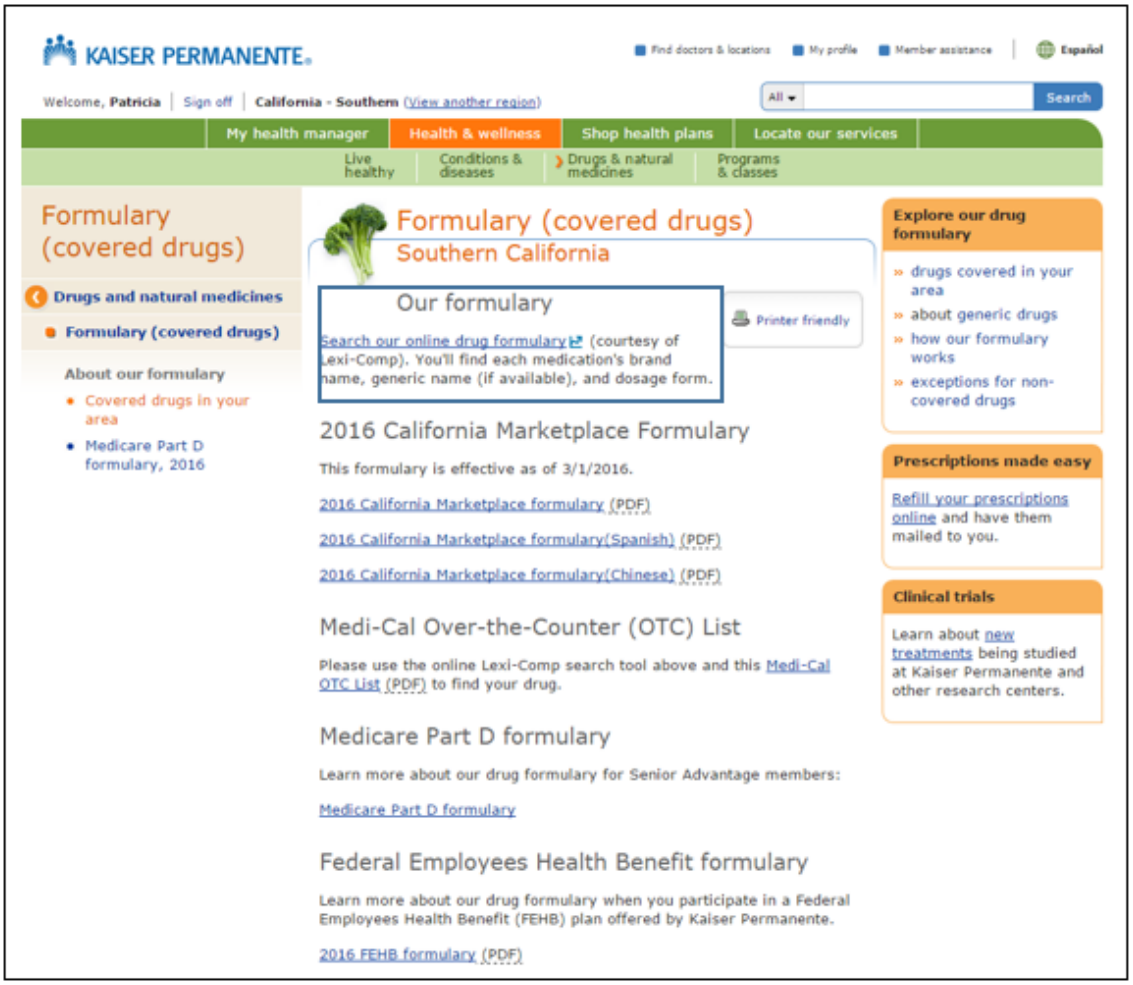
- Prescription drugs that are necessary for Services excluded in the Benefit Booklet or Membership Agreement.
- Non-preferred drugs, unless a non-preferred drug has been specifically prescribed and authorized through the non-preferred drug process.
- Drugs and injections related to the treatment of sexual dysfunction.
- Drugs or injections for treatment of involuntary infertility.
- Drugs to shorten the duration of the common cold.
- Drugs to enhance athletic performance.
- Except where noted, drugs that are available over the counter and by prescription for the same strength.
- Drugs used in the treatment of weight control.
- Any prescription drug packaging other than the dispensing pharmacy's standard packaging.
- Replacement of prescription drugs for any reason, including but not limited to spilled, lost, damaged or stolen prescriptions.
- Unless an exception is approved by the Plan, drugs not approved by the FDA and not in general use as of March 1 of the year immediately preceding the year in which the Plan became effective or was last renewed.

To locate a Network Pharmacy, view the formulary, learn more about mail order or print a claim form, sign on to *kp.org* or call OptumRx at 1-866-427-7701.


KAISER PERMANENTE
Find doctors & locations
My profile
Member assistance
Español
Welcome, Patricia
Sign off
California - Southern (View another region)
All
Search
My health manager
Health & wellness
Shop health plans
Locate our services
New members: Get started
My medical record
Pharmacy center
Appointment center
My coverage & costs
My message center
My Health Manager
My message center
Email your doctor's office with routine questions securely and conveniently. You can also contact Member Services and our Web manager.
Appointment center
You can schedule appointments online, quickly and conveniently. You can also view or cancel upcoming appointments, or view past visits in our Appointment center.
My medical record
View test results, immunizations, health reminders, and more in My medical record. Use Act for a Family Member to manage your family's health.
My coverage and costs
Get the facts about your plan and benefits, download forms, pay medical bills, and more in my coverage and costs.
Pharmacy center
You can manage your prescriptions here, or learn about specific medications in our drug encyclopedia.
New members: Get started
Welcome! Use this handy to-do list to access our online health tools. Then take a Total Health Assessment to start making healthy changes.
Thrive | Web awards & accreditations | Privacy practices | Site policies | Disaster Planning Policy | Web site map | Contact Web manager | About us | Careers | Accessibility | Rights & responsibilities | Terms & conditions | Technical information


KAISER PERMANENTE
Find doctors & locations
My profile
Member assistance
Español
Welcome, Patricia
Sign off
California - Southern (View another region)
All
Search
My health manager
Health & wellness
Shop health plans
Locate our services
New members: Get started
My medical record
Pharmacy center
Appointment center
My coverage & costs
My message center
Pharmacy center
My health manager
Pharmacy center
Pharmacy help
Contact a pharmacist
Drug encyclopedia
Drug formulary
Refill by Rx number
My prescriptions
The table below shows the medications we have on file for you. The list may not include medications that you fill outside of Kaiser Permanente pharmacies, or medications that you purchase over the counter. If you don't see a prescription here, you can refill it by Rx number.
For all other pharmacy-related questions, including hours, search our locations for pharmacy phone numbers.
Help with your prescriptions


KAISER PERMANENTE
Find doctors & locations
My profile
Member assistance
Español
Welcome, Patricia
Sign off
California - Southern (View another region)
All
Search
My health manager
Health & wellness
Shop health plans
Locate our services
Live healthy
Conditions & diseases
Drugs & natural medicines
Programs & classes
Formulary (covered drugs)
Drugs and natural medicines
Formulary (covered drugs)
About our formulary
Covered drugs in your area
Medicare Part D formulary, 2016
What is a formulary?
Our formulary is a list of drugs that have been approved for members by our Kaiser Permanente Pharmacy and Therapeutics Committee.
Printer friendly
Your doctor and other clinicians use the formulary to help determine the safest, most effective drugs to prescribe for you.
Find out what drugs are covered in your area.
Reviewed by: Mark Groshek, MD, and David McWaters, PharmD, JD, May 2014
© 2014 Kaiser Permanente
Explore our drug formulary
» drugs covered in your area
» about generic drugs
» how our formulary works
» exceptions for non-covered drugs
Prescriptions made easy
Refill your prescriptions online and have them mailed to you.
Clinical trials
Learn about new treatments being studied at Kaiser Permanente and other research centers.
Thrive | Web awards & accreditations | Privacy practices | Site policies | Disaster Planning Policy | Web site map | Contact Web manager | About us | Careers | Accessibility | Rights & responsibilities | Terms & conditions | Technical information



Durable Medical Equipment (DME)

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.

Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Network Providers.

Oxygen and oxygen dispensing equipment are covered. (Please see the oxygen benefit description for more details regarding your oxygen benefit description.)

When use is no longer prescribed by a Network Physician, DME must be returned. If the equipment is not returned, you must pay the Plan or its designee the fair market price, established by KPIC, for the equipment.

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

Durable Medical Equipment Exclusions:

- Electronic monitors of bodily functions, except infant apnea monitors are covered.
- Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
- Non-medical items such as sauna baths or elevators.
- Exercise or hygiene equipment.
- Comfort, convenience, or luxury equipment or features.
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings and ace-type bandages.
- Replacement of lost equipment.
- Repair, adjustments or replacements necessitated by misuse.
- More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.
- Wigs and Toupees

Prosthetic Devices

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:

- Internally implanted devices for functional purposes, such as pacemakers and hip joints.
- Prosthetic devices for Participants who have had a mastectomy. The 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.
- Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate in newborn Participants are covered when prescribed by a Network Physician and obtained from sources designated by the Plan.
- Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Network Physician, as Medically Necessary and when obtained from sources designated by the Plan.

Prosthetic Devices Exclusions:

- Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate in newborn Participants, as described above.
- Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
- More than one prosthetic device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Replacement of lost prosthetic devices.
- Repairs, adjustments or replacements necessitated by misuse.

Orthotic Devices

Orthotic devices are those rigid or semi-rigid external devices, other than casts, 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.

Orthotic Devices Exclusions:

- Corrective shoes and orthotic devices for podiatric use and arch supports.
- Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate for newborn Participants is covered when prescribed by a Network Physician, unless the Participant is covered for these Services under a dental insurance policy or contract.
- Experimental and research braces.
- More than one orthotic device for the same part of the body, except for covered replacements; spare devices or alternate use devices.
- Replacement of lost orthotic devices.
- Repairs, adjustments or replacements necessitated by misuse.

Early Childhood Intervention Services

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 are covered for Early Intervention Services (EIS) up to the maximum amount permitted by State law. EIS are not subject to any Copayments or Coinsurance; or to any plan year Out-of-Pocket Maximum or Lifetime Maximum.

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

This Service is in addition to the Autism Service as stated in this Benefits Booklet.

Limitations:
The maximum amount of coverage does not apply to:

a. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical condition; or
b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Education Act".

Early Childhood Intervention Services Exclusions:

- Respite care;
- Non-emergency medical transportation;
- Service coordination;
- Assistive technology, not to include durable medical equipment that is otherwise covered under the Plan;
- Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended; and
- Services that are not provided pursuant to Services that are not provided pursuant to C.R.S. § 10-16-104 (1.3)(a)(II).

Family Planning Services

The following types of Services and supplies are covered as described under separate headings in this "Benefits and Cost Sharing" section**.**

Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control.

Tubal ligations, Vasectomies and Termination of pregnancy for Medical Necessity, rape and incest is covered.

Implantable time released and injectable contraceptives and contraceptive devices that require placement by medical personnel, such as IUDs are covered. This includes the professional services required for administration or placement.

Exclusions:
Voluntary termination of pregnancy.

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

Contraceptive drugs and devices are not covered under this section (see the "Drugs, Supplies and Supplements" section).

Health Education Services

The Plan provides health education appointments to support understanding of chronic diseases such as diabetes and hypertension. Also covered is professional instruction for self-care on numerous topics including stress management and nutrition.

Hearing Aids

The following Services are covered up to the benefit limit listed in the "Summary Chart":

- Tests to determine the appropriate Hearing Aid model; and
- Tests to determine the efficacy of the prescribed Hearing Aid; and
- Visits for fitting, counseling, adjustment, cleaning and inspection after the warranty is exhausted; and
- One Hearing Aid per ear every 60 months.

You do not need to purchase aids for both ears at the same time. The replacement time limit begins at the initial point of sale for each ear and is tracked separately for each ear. Two Hearing Aids are covered only when both are required to provide significant improvement that is not achievable with only one Hearing Aid as determined by a Network Provider.

Exclusions:

- Hearing Aids prescribed or ordered prior to enrollment or after termination of coverage.
- Coverage for any Hearing Aid if payment has been made for an aid for the same ear within the benefit time limit.
- Replacement parts for Hearing Aids.
- Replacement of lost or broken Hearing Aids.
- Replacement batteries.
- Repair of Hearing Aids beyond the warranty.
- Directly implanted Hearing Aids and associated surgery.
- Persons over the age of 18.

Home Health Care

The Plan covers skilled nursing care, home health aide Services and medical social Services:

a. only on a Part-Time Care or Intermittent Care basis; and
b. only within our Service Area; and

c. only if you are confined to your home; and
d. only if a Network Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services, when clinically indicated, are furnished up to 28 hours per week combined over any number of days per week and furnished less than eight (8) hours per day. Additional time up to 35 hours per week but fewer than eight (8) hours per day may be Authorized on a case-by-case basis.

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

Home Health Care Exclusions:

- Custodial care.
- Homemaker Services.
- Care that the Plan determines may be appropriately provided in a Network Facility or Network Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

Home Infusion Services

Home infusion therapy is the administration of drugs in your home using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Home infusion includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by the oral or enteral route as determined by a Network Physician. The infusion therapy must be delivered by a licensed pharmacy. Home Services are also provided to ensure proper patient education and training and to monitor the care of the patient in the home. These Services may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. You do not need to be confined to your home to receive home infusion Services. The following are covered home infusion Services:

- Administration.
- Professional pharmacy Services.
- Care coordination.
- All necessary supplies and equipment, including delivery and removal of supplies and equipment.
- Drugs and Biologicals.
- Nursing visits related to infusion.

Hospice Care

The Plan covers hospice care for terminally ill Participants inside our Service Area. If a Network Physician diagnoses you with a terminal illness and

determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

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

The Plan covers the following Services and other benefits when: (1) prescribed by a Network Physician and the hospice care team, and (2) received from a licensed hospice Authorized in writing:

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

Special Services Program (Pre Hospice)

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

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

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

Infertility Services

The Plan covers the following Services: (a) Services for diagnosis and treatment of involuntary infertility, including lab, X-ray and artificial insemination; and (b) artificial insemination, except for donor semen, donor eggs and Services related

to their procurement and storage. X-ray and laboratory procedures in conjunction with conception by artificial means are provided.

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

Infertility Services Exclusions:

- Services to reverse voluntary, surgically induced infertility.
- All Services and supplies (other than artificial insemination) related to conception by artificial means (Assistive Reproductive Technology) (GIFT/ZIFT and IVF), prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer. These exclusions apply to fertile as well as infertile individuals or couples.

Mental Health Services

The Plan covers mental health Services as specified below, including evaluation and Services for conditions which, in the judgment of a Network Physician, would be responsive to therapeutic management.

Outpatient Therapy

The Plan covers diagnostic evaluation, individual therapy, psychiatric treatment and psychiatrically oriented child and teenage guidance counseling. Visits for the purpose of monitoring drug therapy are covered. Psychological testing as part of diagnostic evaluation is covered.

Inpatient Services

The Plan covers psychiatric hospitalization (including residential treatment) in a facility designated by the Plan. Hospital Services for psychiatric conditions include all Services of Network Physicians and mental health professionals and the following Services and supplies as prescribed by a Network Physician while you are a registered bed patient: room and board, psychiatric nursing care, group therapy, electroconvulsive therapy, occupational therapy, drug therapy and medical supplies.

Partial Hospitalization

The Plan covers partial hospitalization in a Network Hospital-based program.

Mental Health Services Exclusions:

- Evaluations for any purpose other than mental health treatment, such as child custody evaluations, disability evaluations or fitness for duty/return to

work evaluations, unless a Network Physician determines such evaluation to be Medically Necessary.

- Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder and autism.
- Mental health Services on court order, to be used in a court proceeding, or as a condition of parole or probation, unless a Network Physician determines such therapy to be Medically Necessary.
- Court-ordered testing and testing for ability, aptitude, intelligence or interest.
- Services which are custodial.

Oxygen and Oxygen Equipment

Oxygen and oxygen dispensing equipment used in the Member's home (including an institution used as his or her home) is covered in the Service Area.

Oxygen refills are covered when a Member is temporarily traveling outside the Service Area, if the Member has an existing oxygen order and obtains refills from the Plan's designated oxygen vendor.

Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitative and Habilitative Services

Hospital Inpatient Care, Care in a Network Skilled Nursing Facility and Home Health Care

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

Outpatient Care

The Plan covers four (4) types of outpatient therapy (i.e., physical, occupational, speech and autism therapy) in a Network Facility if, in the judgment of a Network Physician, significant improvement is achievable within a two-month period. See the "Summary Chart."

Multidisciplinary Rehabilitation Services

If, in the judgment of a Network Physician, significant improvement in function is achievable within a two-month period, the Plan covers treatment for up to two (2) months per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Network Skilled Nursing Facility.

The Plan covers multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility.

Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Network Physician and provided by therapists at designated facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists of an initial evaluation, up to six (6) education sessions, up to twelve exercise sessions and a final evaluation to be completed within a two to three-month period.

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

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

Cognitive Therapy
Covered following a neurological event, i.e. acute brain injury, post-surgical procedure, stroke.

Exclusions:
Not covered for learning disabilities, dyslexia, severe dementia, etc.

Therapies for the Treatment of Autism Spectrum Disorders
For children under the age of 19, the Plan covers the following therapies for the treatment of Autism Spectrum Disorders:

- Outpatient physical, occupational and speech therapy in a Network Medical Office when prescribed by a Network Physician as Medically Necessary.

- Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted.

Limitations:

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

Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions:

- 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.

Autism Spectrum Disorders Exclusions:

- Long-term rehabilitation, not including treatment for autism spectrum disorders.

- Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with autism.

Preventive Care Services

Preventive care Services are Services to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Should you receive Services for an existing illness, injury or condition during a preventive care examination, you may be charged an additional Cost Share.

* We do not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or genetic information.

Preventive Services for adults
Age-appropriate preventive medical examination
Discussion with Primary Care Provider regarding alcohol misuse
Discussion with Primary Care Provider regarding obesity and weight management
Abdominal aortic aneurysm—one-time screening by ultrasonography in men age 65 to 75 who have ever smoked*
Blood pressure screening for all adults

Cholesterol screening for adults at higher risk of cardiovascular disease
Colon cancer screening for adults age 50 to 75, includes anesthesia
Prostate cancer screening in men age 50 to 75*
Depression screening for adults
Type 2 diabetes screening for adults with high blood pressure
Discussion with Primary Care Provider regarding aspirin for adults at higher risk of cardiovascular disease
Discussion with Primary Care Provider regarding diet counseling for adults at higher risk for chronic disease
Immunizations for adults (doses, recommended ages, and recommended populations vary):
• Hepatitis A
• Hepatitis B
• Herpes zoster
• Human papillomavirus
• Influenza
• Measles, mumps, rubella
• Meningococcal
• Pneumococcal
• Tetanus, diphtheria, pertussis
• Varicella
Screening for all adults at higher risk for sexually transmitted infections and counseling for prevention of sexually transmitted infections, including:
• HIV
• Gonorrhea
• Syphilis
• Chlamydia
Discussion with Primary Care Provider regarding tobacco cessation
Physical therapy to prevent falls in community-dwelling adults age 65 and older who are at increased risk of falling
Over-the-counter drugs when prescribed by a physician for preventive purposes, including:
• Aspirin to reduce the risk of heart attack
• Oral fluoride for children to reduce the risk of tooth decay
• Folic acid for women to reduce the risk of birth defects
• Iron supplements for children to reduce the risk of anemia
• Female contraceptives that are approved by the Food and Drug Administration (FDA) and are generally available over the counter
• Vitamin D supplements for adults to prevent falls

Lung Cancer Screening (HCR)
Screening for hepatitis B virus infection in adults and adolescents at high risk for infection
Preventive Services for women, including pregnant women*
Age-appropriate preventive medical examination
Discussion with Primary Care Provider regarding chemoprevention in women at higher risk for breast cancer
Discussion with Primary Care Provider regarding inherited susceptibility to breast and/or ovarian cancer
Mammography screening for breast cancer for women age 50 to 74
Mammography screening for breast cancer in other age groups as jointly determined by patient and physician
Anti-Breast Cancer Drug
Cervical cancer screening in women age 21 to 65
Osteoporosis screening for women age 65 or older and women at higher risk
Discussion with Primary Care Provider regarding tobacco cessation
Anemia screening for pregnant women
Urinary tract or other infection screening for pregnant women
Hepatitis B screening for pregnant women at their first prenatal visit
Discussion with Primary Care Provider about folic acid supplements for women who may become pregnant
Rh incompatibility screening for pregnant women and follow-up testing for women at higher risk
Routine prenatal care visits
Discussion with Primary Care Provider regarding preconception care
Discussion with Primary Care Provider about interventions to promote and support breastfeeding and comprehensive lactation support and counseling
Provision of breastfeeding equipment
Gestational diabetes screening for pregnant women between 24 and 28 weeks of gestation and for pregnant women identified to be at high risk for diabetes
Discussion with Primary Care Provider about interpersonal and domestic violence
Female sterilizations (includes anesthesia)
Prescribed, FDA-approved, contraceptive devices and contraceptive drugs: discussion with Primary Care Provider about contraceptive methods
Over-the-counter folic acid for women to reduce the risk of birth defects when prescribed by a physician for preventive services
For women who have family member with breast, ovarian, tubal or peritoneal cancer, screening for family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2)

Genetic counseling for women with positive screening results
BRCA genetic testing when clinically indicated after genetic counseling
Breast cancer chemoprevention – Consultation and medications prescribed for risk reduction of primary breast cancer in high-risk women over 35 years of age
Preventive Services for children
Age-appropriate preventive medical examination
Medical history for all children throughout development
Height, weight, and body mass index measurements for children
Behavioral assessments for children of all ages by Primary Care Provider
Developmental screening for children under 3 years and surveillance throughout childhood by Primary Care Provider
Discussion with Primary Care Provider regarding alcohol and drug use assessments for adolescents
Autism screening for children at age 18 months and 24 months by Primary Care Provider
Cervical dysplasia screening for sexually active females*
Congenital hypothyroidism screening for newborns
Phenylketonuria (PKU) screening in newborns
Dyslipidemia screening for children at higher risk of lipid disorders
Oral health risk assessment for young children by Primary Care Provider
Lead screening for children at risk of exposure
Discussion with Primary Care Provider regarding obesity screening and counseling
Gonorrhea prevention medication for the eyes of all newborns
Hearing screening for all newborns
Vision screening for all children
Hematocrit or hemoglobin screening for children
Hemoglobinopathies or sickle cell screening for newborns
Tuberculin testing for children at higher risk of tuberculosis
HIV screening for adolescents at higher risk
Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk
Discussion with Primary Care Provider regarding fluoride supplements for children who have no fluoride in their water source
Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption through age 5 years
Discussion with Primary Care Provider regarding iron supplements for children age 6 months to 12 months who are at risk for anemia
Over-the-counter drugs when prescribed by a physician for preventive purposes: • Iron supplements for children to reduce the risk of anemia • Oral fluoride for children to reduce the risk of tooth decay

Immunizations for children from birth to 18 years (doses, recommended ages, and recommended populations vary):
• Diphtheria, tetanus, pertussis
• Haemophilus influenzae type B
• Hepatitis A
• Hepatitis B
• Human papillomavirus
• Inactivated poliovirus
• Influenza
• Measles, mumps, rubella
• Meningococcal
• Pneumococcal
• Rotavirus
State- or region-mandated services (Colorado)
Breast cancer screenings for all at-risk individuals regardless of age
Additional information about preventive Services
Preventive and other Services provided during the same visit
There are some additional things to keep in mind about coverage for mandated preventive Services that are provided along with other Services during the same visit:
The following Cost Share rules apply when a mandated preventive Service is provided during an office visit:
If the preventive Service is billed separately (or is tracked as individual encounter data separately) from the office visit, then cost sharing may apply to the office visit.
• If the primary purpose of the office visit is the delivery of the preventive service, then no cost sharing may apply to the office visit.
• If the primary purpose of the office visit is not the delivery of the preventive service, then cost sharing may apply to the office visit.

Reconstructive Surgery

The Plan covers reconstructive surgery when a Network Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery, or (b) will correct a congenital defect, disease or anomaly in order to produce significant improvement in physical function, or (c) will treat congenital hemangioma (known as port wine stains) on the face and neck. Following Medically Necessary removal of all or part of a breast, the Plan covers

reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

Reconstructive Surgery Exclusions:

- Plastic surgery or other cosmetic Services and supplies intended primarily to change your appearance, including cosmetic surgery related to bariatric surgery.

Network Skilled Nursing Facility Care

The Plan covers up to 100 days per year of skilled inpatient Services in a licensed Network Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Network Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. The Plan covers the following Services:

- Room and board
- Nursing care
- Medical social Services
- Medical and biological supplies
- Blood, blood products and their administration

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

Note: Drugs are covered, but not under this section (see "Drugs, Supplies and Supplements"). DME and prosthetics and orthotics are covered, but not under this section (see "Durable Medical Equipment (DME)," "Prosthetics Devices" and "Orthotic Devices").

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

Network Skilled Nursing Facility Care Exclusion:

- Custodial Care, as defined in the "Exclusions" subsection of the "Exclusions and Limitations" section below.

Transplant Services

Transplants are covered on a basis as follows:

a. Covered transplants are limited to kidney transplants, heart transplants, heart-lung transplants, liver transplants, liver transplants

for children with biliary atresia and other rare congenital abnormalities, small bowel transplants, small bowel and liver transplants, lung transplants, cornea transplants, simultaneous kidney-pancreas transplants and pancreas alone transplants.

b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.

c. If all medical criteria is met, the Plan covers stem cell rescue and transplants of organs, tissue or bone marrow.

Related Prescription Drugs

Prescribed post-surgical immunosuppressive outpatient drugs required as a result of a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance shown on the "Summary Chart."

Terms and Conditions

- The Plan, and Network Physicians do not undertake to provide a donor or donor organ or bone marrow or cornea, or to assure the availability of a donor or donor organ or bone marrow or cornea, or the availability or capacity of referral transplant facilities approved by the Plan. However, in accord with Plan guidelines for living transplant donors, the Plan provides certain donation-related Services for a donor, or a person identified as a potential donor, even if the donor is not a Participant. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the Transplant Administrative Offices at 303-636-3214 or TTY 1-800-659-2656.
- Network Physicians determine that the Participant satisfies KP medical criteria before the Participant receives the Services.
- A Network Physician must provide a written referral for care to a Network transplant facility or a Non-Network approved facility. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility selected for the particular transplant, even if another facility within the Service Area could also perform the transplant.
- If, after referral, either a Network Physician or the medical staff of the referral facility determines that the Participant does not satisfy its respective criteria for the Service involved, the Plan's obligation is limited to paying for Covered Services provided prior to such determination.

Transplant Services Exclusions and Limitations:

- Bone marrow transplants associated with high dose chemotherapy for solid tissue tumors, other than bone marrow transplants covered in accord with the Plan, are excluded.
- Non-human and artificial organs and their implantation are excluded.
- Pancreas alone transplants are limited to patients without renal problems who meet established criteria.
- Travel and lodging expenses are excluded, except that in some situations, when you are referred to a non-Network Provider outside our Service Area for transplant Services, as described under "Getting a Referral" in the "How to Obtain Services" section, the Trustmay pay certain expenses that the Plan Authorizes in accord with our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator or the Transplant Administrative Offices at 303-636-3214 or TTY 1-800-659-2656.

Vision Services

The Plan covers wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses.

Professional Services for examinations and fitting of contact lenses are provided at an additional Charge when obtained at Network Medical Offices.

Vision Services Exclusions:

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

X-ray, Laboratory and Special Procedures

Outpatient

The Plan covers the following Services:

- Diagnostic X-ray and laboratory tests, Services and materials, including isotopes, electrocardiograms, electroencephalograms and mammograms.
- Therapeutic X-ray Services and materials.
- X-ray and laboratory Services and procedures for the treatment of infertility and conception by artificial means. Special procedures such as MRI, CT, PET and nuclear medicine. Note: Participants 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 plan yearly by the American Medical Association. The Participant is responsible for any applicable Costshare for Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.

Inpatient

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

Exclusions:

- Testing of a Participant for a non-Participant's use and/or benefit.
- Testing of a non-Participant for a Participant's use and/or benefit.

GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this Plan. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits and Cost Sharing" section.

1. Alternative Medical Services. Naturopathy Services, Massage therapy.
2. Certain Exams and Services. Physical examinations and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for: • Employment; • Participation in employee programs; • Insurance; • Disability; • Licensing; • Or on court order or for parole or probation.
3. Cosmetic Services. Services that are intended primarily to change or maintain your appearance, and that will not result in major improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services determined to be "Reconstructive Surgery"
4. Custodial Care. Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.
5. 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 Network Provider, unless the Participant 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 Network 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 and, unless otherwise specified herein, and received at a Plan Hospital, Plan Facility or Skilled Nursing Facility. The following Services for TMJ may be covered if a Network Provider determines they are Medically Necessary: diagnostic X-rays, laboratory testing, physical therapy and surgery.
6. Directed blood donations.

7. Disposable supplies for home use such as:
a. Bandages;
b. Gauze;
c. Tape;
d. Antiseptics;
e. Dressings;
f. Ace-type bandages; and
g. Any other supplies, dressings, appliances or devices not specifically listed as covered.

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

9. Experimental or Investigational Services.
a. A Service is experimental or investigational for a Participant's condition if any of the following statements apply at the time the Service is or will be provided to the Participant. The Service:
i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
ii. is the subject of a current new drug or new device application on file with the FDA; or
iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity or efficacy of the Service; or
iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or
v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity or efficacy of Services; or
vi. the Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by the 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 Participant'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 Participant or the Participant'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 regarding the Service as applied to the Participant'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. The Plan consults Kaiser Permanente and then uses the criteria described above to decide if a particular Service is experimental or investigational.

10. Genetic Testing. Genetic testing unless determined to be Medically Necessary and meets criteria established by Medical Group.
11. Intermediate Care. Care in an intermediate care facility.
12. Routine Foot Care Services. Routine foot care Services that are not Medically Necessary.
13. Services for Members in the Custody of Law Enforcement Officers. Non-Network Provider Services provided or arranged by criminal justice institutions for Participants in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or out-of-Plan non-emergency, non-routine care.
14. 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.
15. 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 the Plan would otherwise cover to treat complications as a result of the non-Covered Service.
16. Travel and Lodging Expenses. Travel and lodging expenses are excluded. The Trust may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines in some situations, when Kaiser Permanente or a Network Provider refers you to a non-Network Provider outside our Service Area for transplant Services. Travel and lodging expenses are not covered for Participants who are referred to a non-Network Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator or the Transplant Administrative Offices.
17. 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 the Plan.
18. Weight Management Facilities. Services received in a weight management facility.
19. Workers' Compensation or Employer's Liability. Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. The Plan will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but the Plan may recover Charges for any such Services from the following sources: a. Any source providing a Financial Benefit or from whom a Financial Benefit is due. b. You, to the extent that a Financial Benefit is provided or payable or would have been provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

20. Drugs, Supplies and Supplements Exclusions:

a. Drugs for which a prescription is not required by law.
b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
c. Drugs or injections for treatment of sexual dysfunction
d. Any packaging except the dispensing pharmacy's standard packaging.
e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
f. Drugs or injections for the treatment of infertility
g. Drugs to shorten the length of the common cold.
h. Drugs to enhance athletic performance.
i. Drugs for the treatment of weight control.
j. Drugs available over the counter except where noted in your Summary Chart and by prescription for the same strength.
k. Unless approved by the Plan, drugs:
i. Not approved by the FDA; and
ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
l. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
m. Prescription drugs necessary for Services excluded under the Plan.

21. Elective Abortions.

22. Infertility Services:

a. Services to reverse voluntary, surgically induced infertility.
b. All Services and supplies (other than artificial insemination, surgery and other services as defined in the Benefits section) related to conception by artificial means. This means prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

23. Vision Hardware. (Eyeglass lenses and frames, contact lenses and contact lens examinations, fittings and dispensing)

24. Transgender Surgery exclusions:

- Non-Genital Surgery - Male to Female rhinoplasty, lipoplasty of the waist, facial bone reduction, face lifts, blepharoplasty, voice modification surgery) or Female to Male (liposuction and cosmetic chest reconstruction).
- Non-Genital Surgery – Female to Male (liposuction to reduce fat in hips thighs and buttocks; cosmetic chest reconstruction
- Cosmetic Surgery - Male to Female or Female to Male.
- Electrolysis or laser hair removal, except for facial hair removal or when used to prepare the perineum for SRS (Sexual Reassignment Surgery) and pharmaceuticals such as Vaniqa
- Voice therapy lessons.
- Sperm procurement and storage in anticipation of future infertility, Gamete preservation and storage in anticipation of future infertility, Cryopreservation of fertilized embryos in anticipation of future infertility.
- Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics**.**
- Referrals outside US.

General Limitations

Network Providers will try to provide or arrange for the provision of Covered Services in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Network Provider's facility, complete or partial destruction of facilities, or labor disputes. Neither the Plan, KPIC, nor any Network Providers shall have any liability for delaying or failing to provide Services in the event of this type of unusual circumstance.

Coordination of Benefits

This "Coordination of Benefits" (COB) section describes how payment of claims for Services under the Plan will be coordinated with those of any other plan under which you are entitled to have claims for Services paid.

When Coordination of Benefits Applies

This "Coordination of Benefits" section applies when a Participant or a Dependent has health care coverage under more than one benefit plan under which claims for Services are to be paid.

The order of benefit determination rules described in this "Coordination of Benefits" section govern the order in which each Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan, the one that must pay first, pays in accordance with its terms without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the payments it makes so that payments from all plans do not exceed 100% of the total Allowable Expenses.

Definitions

For purposes of this "Coordination of Benefits" section only, terms are defined as follows:

"**Coverage Plan**" is any of the following that provides payment or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

- Coverage Plan includes: group and non-group insurance, health maintenance organization (HMO) contracts, closed panel 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.

- Coverage Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage, as defined by state law; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other federal governmental plans, unless permitted by law.

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

“**This Coverage Plan**” means 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 Coverage 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.

"**Primary Coverage Plan**" or "**Secondary Coverage Plan**." Order of benefit determination rules determine whether This Coverage Plan is a Primary Coverage Plan or Secondary Coverage Plan when compared to another Coverage Plan covering the person. When This Coverage Plan is primary, it determines payment of claims for Services first before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When This Coverage Plan is secondary, it determines payment of claims for Services after those of another Coverage Plan and may reduce its payments so that all payments and benefits of all Coverage Plans do not exceed 100% of the total Allowable Expense.

"**Allowable Expense**" means a health care expense, including deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of Services (for example an HMO), the reasonable cash value of each Service will be considered an Allowable Expense and a benefit paid. An expense or an expense for a Service that is not covered by any of the Coverage Plans 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 additional examples of expenses or Services that are not Allowable Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.
- If a person is covered by two or more Coverage 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 of the usual and customary fees (or other reimbursement amount) for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more Coverage 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.
- If a person is covered by one Coverage Plan that calculates its benefits or Services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or Services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans. However, if the provider has contracted with the Secondary Coverage Plan to provide the benefit or Service for a payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Coverage Plan to determine its benefits.
- The amount a benefit is reduced by the Primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

“Claim Determination Period” means a plan year.

"**Closed Panel Plan**" is a Coverage Plan that provides health care benefits to covered persons primarily in the form of Services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order of Benefit Determination Rules

When a person is covered by two or more Coverage Plans which pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Coverage Plan(s).

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Coverage Plans state that the complying plan is primary; provided, however, coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be in excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide non-network benefits.

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

D. Each Coverage Plan determines its order of benefits using the first of the following rules that applies:

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

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Coverage 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:

(i) The Coverage Plan of the parent whose birthday falls earlier in the calendar year is primary

(ii) If both parents have the same birthday, the Coverage Plan that has covered the parent the longest is primary.

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

(i) If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

(ii) 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; or

(iii) 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

(iv) 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 dependent child are as follows:

- The Coverage Plan of the custodial parent
- The Coverage Plan of the spouse of the custodial parent
- The Coverage Plan of the non-custodial parent, and then
- The Coverage Plan of the spouse of the non-custodial parent

c. For a dependent child covered under more than one Coverage Plan of individuals who are 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.

3. Active or inactive (retired or laid-off) employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The Coverage Plan covering that same person as a retired or laid-off employee is the Secondary Coverage 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 retiree or laid-off employee. If the other Coverage Plan does not have this rule, and as a result, the Coverage 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.

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber, or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and as a result, the Coverage 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.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber, or retiree longer is primary and the Coverage Plan that covered the person the shorter period of time is the Secondary Coverage Plan.

6. 6. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this "Coordination of Benefits" section. In addition, This Coverage Plan will not pay more than it would have paid had it been the Primary Coverage Plan.

Effect on the Benefits of this Plan

When This Coverage Plan is secondary, it may reduce its benefits so that the total amount of benefits paid or provided by all Coverage Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Coverage 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 the Secondary Coverage Plan that is unpaid by the Primary Coverage Plan. The Secondary Coverage Plan may then reduce its payment by the amount so that when combined with the amount paid by the Primary Coverage Plan, the total benefits paid or provided by all Coverage Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Coverage Plan shall credit to its plan deductible, if any, the amounts that it would have credited to its deductible in the absence of other health care coverage.

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-participating provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

This Coverage Plan complies with the Medicare Secondary Payer regulations. If a Covered Person is also receiving benefits under Medicare, including Medical Prescription Drug Coverage, federal law may require this Plan to be primary. When This Coverage Plan is not primary, the Plan will coordinate benefits with Medicare. This Coverage Plan reduces its Benefits as described below for covered persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

When Medicare would be primary, Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is eligible for, but not enrolled in, Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage plan and receives non-Covered Services because the person did not follow all rules of that plan. Medicare benefits are determined as if the Services were covered under Medicare Parts A and B.
- The person receives Services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the Services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The Services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the Services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

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 Coverage Plan and other Coverage Plans. The Plan has the right to release or obtain any information and make or recover any payments considered necessary in order to administer this "Coordination of Benefits" section. This shall include getting the facts needed from, or giving them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Coverage Plan and other Coverage Plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Coverage Plan must provide any facts needed to apply those rules and determine benefits payable. If you do not provide the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

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

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this "Coordination of Benefits" section, it may receive the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or Services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of Services.

Reductions

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when The Trust has paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means The Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits The Trust has paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to The Trust 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with KPIC in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

  Notifying KPIC, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.

  Providing any relevant information requested by KPIC.

  Signing and/or delivering such documents as The Plan or our agents reasonably request to secure the subrogation and reimbursement claim.

  Responding to requests for information about any accident or injuries.

  Making court appearances.

  Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

  Complying with the terms of this section.

  Your failure to cooperate is considered a breach of contract. As such, The Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with The Plan or our agents. If The Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, The Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, this first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment

from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from The Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, The Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which The Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit The Plan's subrogation and reimbursement rights.
- Benefits paid by The Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and The Plan alleges some or all of those funds are due and owed to The Trust, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon our request, you will assign to us all rights of recovery against third parties, to the extent of the Benefits we have paid for the Sickness or Injury.
- The Plan may, at its' option, take necessary and appropriate action to preserve its' rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name, which

does not obligate us in any way to pay you part of any recovery The Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Trust, without its' written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Trust for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

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

Harrington Health
3701 Boardman-Canfield Rd., Bldg B
Canfield, OH 44406-7005

In order for the Plan to determine the existence of any rights the Plan may have and to satisfy those rights, you must complete and send all consents, releases, authorizations, assignments, and other documents, including lien forms directing

your attorney, the third party, and the third party's liability insurer to pay the Trust directly. You may not agree to waive, release, or reduce the Plan's rights under this provision without the Plan's prior written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third 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 the Plan's liens and other rights to the same extent as if You had asserted the claim against the third party. The Plan may assign its rights to enforce liens and other rights.

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

Surrogacy arrangements

If you enter into a Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A Surrogacy Arrangement is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Copayments and or Coinsurance for these Services; you will be credited any such payments toward the amount you must reimburse the Trust under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to the Plan your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, we will also have an equitable lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement to the address listed below, 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) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement and
- Any other information we request in order to satisfy our rights

Harrington Health
3701 Boardman-Canfield Rd., Bldg B
Canfield, OH 44406-7005

You must complete and send all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary to determine the existence of any rights the Plan may have under this "Surrogacy arrangements" section and to satisfy those rights. you may not agree to waive, release, or reduce the Plan's rights under this "Surrogacy arrangements" section without the Plan's prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third 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 as if you had asserted the claim against the third party. The Plan may assign our rights to enforce our liens and other rights.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, the Plan will not pay the Department of Veterans Affairs, and when the Plan covers any such Services the Plan may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. The Plan will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but the Plan may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

DISPUTE RESOLUTION

Grievances

Kaiser Permanente (KP) is committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Network Facilities, or you can call Member Services at the number on your KPIC ID card.

You can file a grievance for any issue. Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received.
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room.
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility.

Your grievance must explain your issue, such as the reasons why you are dissatisfied about Services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction.

Grievances may be submitted in one of the following ways:

- to the Member Services Department at a Network Facility;
- by calling our Member Service Call Center at the number on the back of your ID card; or
- through our Web site at **kp.org/cuhealthplan**.

KP will send you a confirmation letter within five days after we receive your grievance. KP will send you our written decision within 30 days after we receive your grievance.

Note: If your issue is resolved to your satisfaction by the end of the next business day after your grievance is received orally, by fax, or through our website, and a Member Services representative notifies you orally about our decision, we will not send you a confirmation letter or a written notification.

CLAIMS AND APPEALS

To obtain payment from the Plan for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this "CLAIMS AND APPEALS" section. You may appoint an authorized representative to help you file your claim or appeal. A written authorization must be received from you before any information will be communicated to your representative.

If you miss a deadline for filing a claim or appeal, review may be declined. Before you can file a civil action you must meet any deadlines and exhaust the claims and appeals procedures set forth in this "CLAIMS AND APPEALS" section. The Plan does not charge you for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

How to File a Claim

Network Providers are responsible for submitting claims for their services on your behalf and will be paid directly by the Plan for the services they render. If a Network Provider bills you for a Covered Service (other than for Cost Sharing), please call customer service at the telephone number listed in the "CUSTOMER SERVICE PHONE NUMBERS" section.

For services rendered by Non-Network providers, where the provider agrees to submit a claim on your behalf, eligible claims payment to the provider will require a valid assignment of benefits. Even if the Non-Network Provider agrees to bill on your behalf, you are responsible for making sure that the claim is received within 365 days of the date of service and that all information necessary to process the claim is received.

To receive reimbursement for Services you have paid for, you must complete and mail a claim form (or write a letter) to the Claims Administrator at the address listed in the "CUSTOMER SERVICE PHONE NUMBERS" section, within 365 days after you receive Services. The claim form (or letter) must explain the Services, the date you received them, where you received them, who provided them, and why you think the Trust should pay for them. Include a copy of the bill and any supporting documents. Your claim form (or letter) and the related documents constitute your claim.

Your claim must include all of the following information:

- Patient name, address, and KPIC ID card medical or health record number
- Date(s) of service
- Diagnosis
- Procedure codes and description of the Services
- Charges for each Service
- The name, address, and tax identification number of the provider
- The date the injury or illness began
- Any information regarding other medical coverage

To obtain a medical or pharmacy claim form, visit **kp.org/cuhealthplan**; select the My Health Manager tab, then My Medial Record. The claim form will inform you about other information that you must include with your claim.

If the Trust pays a Post-Service Claim, it will pay you directly, except that it will pay the provider if one of the following is true:

- Before the claim is processed, a written notice is received indicating you have assigned your right to payment to the provider or
- Your claim includes a written request that the Trust pay the provider

If you have any questions about submitting a claim for payment for a Service from a Non-Network Provider, please call customer service at the telephone number listed on your KPIC ID card or in the "CUSTOMER SERVICE PHONE NUMBERS" section.

Restrictions Against Assignment of Benefits

Benefits, rights and interests under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, or execution of levy of any kind, either voluntary or involuntary, by any person, and any such attempts shall be void. However, a Participant may direct that benefits payable to him be paid to an institution in which he or his covered Dependent is hospitalized or to any other provider of services or supplies authorized under this Plan. Notwithstanding the foregoing, the Plan reserves the right to refuse to honor such direction and to make payment directly to the Participant. No payment by the Trust pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of services or supplies except to the extent the Plan actually chooses to do so.

Timing of Claim Determinations

The Plan adheres to certain time limits when processing claims for benefits. If you do not follow the proper procedures for submitting a claim, the Plan will notify you of the proper procedures within the time frames shown in the chart below. If additional information is needed to process your claim, the Plan will notify you within the time frames shown in the chart below, and you shall be provided additional time within which to provide the requested information as indicated in the chart below in this "Timing of Claim Determinations" section.

The Plan will make a determination on your claim within the time frames indicated below based upon the type of claim: Urgent Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim.

An "Urgent Care Claim" is any claim for a Service with respect to which the application of the time periods for making non-urgent care determinations either (a) could seriously jeopardize your life, health, or ability to regain maximum function, 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 that are the subject of the claim.

A "Pre-Service Claim" is any claim for a Service with respect to which the terms of the Plan condition receipt of the Service, in whole or in part, on approval by the Plan of the Service in advance.

A "Post-Service Claim" is any claim for a Service that is not a Pre-Service Claim or an Urgent Care Claim.

A "Concurrent Care Claim" is any claim for Services that are part of an on-going course of treatment that was previously approved by the Plan for a specific period of time or number of treatments.

Type of Notice or Claim Event	Urgent Care Claim	Pre-Service Care Claim	Post-Service Care Claim
Plan Notice of Failure to Follow the Proper Procedure to File a Claim	Not later than 24 hours after receiving the improper claim.	Not later than 5 days after receiving the improper claim.	Not applicable.
Plan Notice of Initial Claim Decision	If the claim when initially filed is proper and complete, a decision will be made as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving the initial claim. If the claim is not complete, the Plan shall notify you as soon as possible, but not later than 24 hours of receipt of the claim. You shall have 48 hours to provide the information necessary to complete the claim. A decision will be made not later than 48 hours after the administrator receives the requested information, or within 48 hours after the expiration of the 48-hour deadline for submitting additional information, whichever is earlier.	If the claim when initially filed is proper and complete, a decision will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the Plan. You shall be notified within the initial 15 days if an extension will be needed by the Plan. The notice shall state the reason for the extension. A decision will be made not later than 15 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 15	A decision will be made within a reasonable amount of time, but not later than 30 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the Plan. You shall be notified within the initial 30 days if an extension will be needed by the Plan. The notice shall state the reason for the extension. A decision will be made not later than 30 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 30 day period, and shall have 45 days to provide the additional information

		day period, and shall have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information, or within 15 days after the expiration of the 45-day deadline for submitting additional information, which-ever is earlier.	requested. A decision will be made within 15 days after receiving the additional information or, within 15 days after the expiration of the 45-day deadline for submitting additional information, whichever is earlier.

If you have a Concurrent Care Claim that is also an Urgent Care Claim to extend a previously approved on-going course of treatment provided over a period of time or number of treatments, Plan will make a determination as soon as possible, taking into account the medical exigencies, and notify you of the determination within twenty-four (24) hours after receipt of the claim, provided that the claim was made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your request for extended treatment is not made at least twenty-four (24) hours prior to the end of the prescribed period of time or number of treatments, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If your Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by Plan amendment or termination) before the end of the period of time or number of treatments, you will be notified by the Plan sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit.

If a Claim Is Denied

If all or part of your claim is denied, the Plan will send you a written notice. If the notice of denial involves an Urgent Care Claim, the notice may be provided orally (a written or electronic confirmation will follow within 3 days). This notice will include:

- Information sufficient to identify the claim involved;

- The reasons for the denial, including references to specific Plan provisions upon which the denial was based;
- If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why the information or materials are necessary;
- A description of the Plan's internal and external review procedures and the time limits that apply to them;
- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request;
- The notice will also state how and when to request a review of the denied claim;
- If applicable, the notice will also contain a statement of your right to bring a civil action following an adverse benefit determination following completion of all levels of review;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance ombudsman.

How to Appeal a Denied Claim

You may appeal a denied claim by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of the denial notice. Send the written request to the Plan at:

Kaiser Permanente Insurance Company – Appeals
3701 Boardman-Canfield Road
Canfield, OH 44406

You may instead fax your appeal to 614-212-7110.

To appeal a pharmacy claim, submit your form to:

Kaiser Permanente
Attn: SFAS National Self Funding
3840 Murphy Canyon Rd
San Diego, CA 92123
Fax: 858-614-7912

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. The Plan may require you to submit such additional facts, documents, or other material as it may deem necessary or appropriate in making its review.

In addition, under PHS ACT Section 279.3, states with Consumer Assistance Programs may be available in your state to assist you in filing your appeal. A list of state Consumer Protection Agencies is available on KP.org/cuhealthplan (Log into My Health Manager, select Manage My Plan & Coverage, then click on Claims Summary list of the State Assistance Programs under the Resources banner) and listed below.

STATES WITH CONSUMER ASSISTANCE PROGRAMS UNDER PHS ACT SECTION 2793

** Current as of February 27, 2013 **

(Periodic updates posted at www.dol.gov/ebsa/healthreform & http://cciio.cms.gov/programs/consumer/capgrants/index.html)

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

State	Contact Information
Alabama	No program
Alaska	No program
American Samoa	Not yet operational
Arizona	No program
Arkansas	Arkansas Insurance Department, Consumer Services Division 1200 West Third St. Little Rock, AR 72201 (855) 332-2227 Insurance.consumers@arkansas.gov
California	California Consumer Assistance Program Operated by the California Department of Managed Health Care and Department of Insurance 980 9th St, Suite #500 Sacramento, CA 95814 (888) 466-2219 http://www.HealthHelp.ca.gov
Colorado	No program
Connecticut	Connecticut Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 (866) 466-4446 www.ct.gov/oha healthcare.advocate@ct.gov
Delaware	Delaware Department of Insurance 841 Silver Lake Blvd Dover, DE 19904 (800) 282-8611 consumer@state.de.us

State	Contact Information
District of Columbia	DC Office of the Health Care Ombudsman and Bill of Rights 899 North Capitol Street, NE, 6th Floor, Room 6037 Washington, DC 20002 (877) 685-6391 healthcareombudsman@dc.gov
Florida	Not yet operational
Georgia	Georgia Office of Insurance and Safety Fire Commissioner Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 http://www.oci.ga.gov/ConsumerService/Home.aspx
Guam	Guam Department of Revenue and Taxation 1240 Army Drive Barrigada, Guam 96921 (671) 635-1844
Hawaii	No program
Idaho	No program
Illinois	Illinois Department of Insurance 320 W. Washington St, 4th Floor Springfield, IL 62767 (877) 527-9431 http://www.insurance.illinois.gov DOI.Director@illinois.gov
Indiana	No program
Iowa	No program
Kansas	Kansas Insurance Department Consumer Assistance Division 420 SW 9th Street Topeka, KS 66612 (800) 432-2484 (in state) (785) 296-7829 (all others) http://www.ksinsurance.org CAP@ksinsurance.org
Kentucky	Kentucky Department of Insurance, Consumer Protection Division P.O. Box 517 Frankfort, KY 40602 (877) 587-7222 http://healthinsurancehelp.ky.gov DOI.CAPOmbudsman@ky.gov
Louisiana	No program
Maine	Consumers for Affordable Health Care 12 Church Street, PO Box 2490 Augusta, ME 04338-2490 (800) 965-7476 www.mainecahc.org consumerhealth@mainecahc.org

State	Contact Information
Maryland	Maryland Office of the Attorney General Health Education and Advocacy Unit 200 St. Paul Place, 16th Floor Baltimore, MD 21202 (877) 261-8807 http://www.oag.state.md.us/Consumer.HEAU.htm heau@oag.state.md.us
Massachusetts	Massachusetts Consumer Assistance 30 Winter Street, Suite 1004 Boston, MA 02108 (888) 211-6168 www.massconsumerassistance.org
Michigan	Michigan Health Insurance Consumer Assistance Program (HICAP) Michigan Office of Financial and Insurance Regulation P.O. Box 30220 Lansing, MI 48909 (877) 999-6442 http://michigan.gov/ofir Ofir-hicap@michigan.gov
Minnesota	No program
Mississippi	Health Help Mississippi 800 North President St Jackson, MS 39202 (877) 314-3843 http://www.healthhelpms.org healthhelpms@mhap.org
Missouri	Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov consumeraffairs@insurance.mo.gov
Montana	Office of the Commissioner of Securities & Insurance 840 Helena Ave Helena, MT 59601 (800) 332-6148 (in-state only) http://www.csi.mt.gov
Nebraska	No program
Nevada	Office of Consumer Health Assistance Governor's Consumer Health Advocate 555 East Washington Ave #4800 Las Vegas, NV 89101 (702) 486-3587 (888) 333-1597 http://www.govcha.nv.gov cha@govcha.nv.gov

State	Contact Information
New Hampshire	New Hampshire Department of Insurance 21 South Fruit Street, Suite 14 Concord, NH 03301 (800) 852-3416 www.nh.gov/insurance consumerservices@ins.nh.gov
New Jersey	New Jersey Department of Banking and Insurance 20 West State Street, PO Box 329 Trenton, NJ 08625 (800) 446-7467 (888) 393-1062 (appeals) http://www.state.nj.us/dobi/consumer.htm ombudsman@dobi.state.nj.us
New Mexico	NMPRC Insurance Division Health Insurance Consumer Assistance Program 1120 Paseo De Peralta Santa Fe, NM 87504 (855) 857-0972 or (888) 427-5772 (505) 476-0326 (fax) http://nmprc.state.nm.us/id.htm mchb.grievance@state.nm.us
New York	Community Service Society of New York, Community Health Advocates 105 East 22nd Street, 8th floor New York, NY 10010 (888) 614-5400 http://www.communityhealthadvocates.org/ cha@cssny.org
North Carolina	Mailing Address: North Carolina Department of Insurance Health Insurance Smart NC 1201 Mail Service Center Raleigh, NC 27699-1201 (877) 885-0231 http://ncdoi.com/Smart/ Delivery Service/Physical Address: North Carolina Department of Insurance Health Insurance Smart NC 430 N. Salisbury Street Raleigh, NC 27603
North Dakota	No program
Northern Mariana Islands	Not yet operational
Ohio	No program
Oklahoma	Oklahoma Insurance Department Five Corporate Plaza 3625 Northwest 56th Street, Suite 100 Oklahoma City, OK 73112 (800) 522-0071 (in-state only) (405) 521-2991 http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html

State	Contact Information
Oregon	Oregon Health Connect 1435 NE 81st Ave. Suite 500 Portland, OR 97213-6759 (855) 999-3210 oregonhealthconnect.org healthconnect@211info.org
Pennsylvania	Pennsylvania Department of Insurance 1209 Strawberry Square Harrisburg, PA 17111 (877) 881-6388 www.insurance.pa.gov
Puerto Rico	Puerto Rico Oficina de la Procuradora del Paciente 1215 Ponce de Leon PDA 18 Santurce, PR 00907 (800) 981-0031 www.pacientes.gobierno.pr querellas@opp.gobierno.pr
Rhode Island	Rhode Island Consumer Assistance Program Rhode Island Parent Information Network, Inc. 1210 Pontiac Avenue Cranston, RI 02920 (855) 747-3224 www.RIREACH.org
South Carolina	South Carolina Department of Insurance Consumer and Individual Licensing Services P.O. Box 100105 Columbia, SC 29202 (800) 768-3467 http://www.doi.sc.gov consumers@doi.sc.gov
South Dakota	No program
Tennessee	Tennessee Department of Commerce and Insurance 500 James Robertson Pkwy Davy Crockett Tower, 4th floor Nashville, TN 37243-0574 (615) 741-2218 (800) 342-4029 (615) 532-7389 (Fax) www.tn.gov/commerce/insurance
Texas	Texas Consumer Health Assistance Program Texas Department of Insurance Mail Code 111-1A 333 Guadalupe P.O. Box 149091 Austin, TX 78714 (855) 839-2427 (855-TEX-CHAP) www.texashealthoptions.com chap@tdi.state.tx.us

State	Contact Information
Utah	No program
Vermont	Vermont Legal Aid 264 North Winooski Ave. Burlington, VT 05402 (800) 917-7787 www.vtlegalaid.org
Virginia	Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov
Virgin Islands	U.S. Virgin Islands Division of Banking and Insurance 1131 King Street Suite 101 Christiansted St. Croix, VI 00820 (340) 773-6459 http://ltg.gov.vi
Washington	Washington Consumer Assistance Program 5000 Capitol Blvd Tumwater, WA 98501 (800) 562-6900 http://www.insurance.wa.gov cap@oic.wa.gov
West Virginia	West Virginia Office of the Insurance Commissioner Consumer Service Division P.O. Box 50540 Charleston, WV 25305 (888) 879-9842 http://www.wvinsurance.gov
Wisconsin	No program
Wyoming	No program

Deemed Exhaustion

If the Plan does not adhere to the Federal Appeals process as described below, it will be deemed that you have exhausted the appeals process. This means that you are no longer required to stay within the mandated internal appeal process. Exception:

- Violations which do not cause and are not likely to cause prejudice or harm and,
- Can be demonstrated were for good cause or due to matters beyond the control of the Plan and,
- The violation occurred in the context of an on-going, good faith exchange of information between the Plan and you.

You may request a written explanation of the violation and it will be provided to you within 10 days of your request. Such explanation will include a specific description of the basis, if any, on which the appeal process is not deemed to be exhausted. If an external review organization or court determines your appeal is not deemed exhausted, you have the right to resubmit your appeal request and continue the internal appeal process.

Procedures on Appeal

As part of the review procedure, you may submit written comments, documents, records, and other information relating to the claim.

Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.

The Plan will review the claim, taking into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The review shall not afford deference to the initial claim denial and shall be conducted by the Claims Fiduciary, Harrington Health Services, Inc., who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary, the Claims Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that

health care professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of that individual).

Upon request, the Plan will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Timing of Initial Appeal Determinations

Plan will act upon each request for a review within the time frames indicated in the chart below:

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 24 hours after receiving the appeal.	Not later than 15 days after receiving the appeal	Not later than 30 days after receiving the appeal.

Notice of Determination on Initial Appeal

Within the time prescribed in the "Timing of Initial Appeal Determinations" section, KPIC will provide you with written notice of its decision. If the Plan determines that benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice shall state:

- The reasons for the denial, including references to specific the Plan provisions upon which the denial was based;
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, Experimental, or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such

explanation will be provided free of charge upon request.

- For Pre-Service Claims and Post-Service Claims, the notice will also state how and when to request a review of the denial of the initial appeal.
- For Urgent Care Claims, the notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain the information about those procedures.

How to File a Final Appeal

For Pre-Service Claims and Post-Service Claims, you may appeal the denial of your initial appeal by submitting a written request for review to the Plan. You must make the appeal request within 60 days after the date of notice that your appeal is denied. Send the written request to Plan at:

Kaiser Permanente Insurance Company – Appeals
3701 Boardman-Canfield Road
Canfield, OH 44406

You may instead fax your appeal to 614-212-7110.

To appeal a pharmacy claim, submit your form to:

Kaiser Permanente
Attn: SFAS National Self Funding
3840 Murphy Canyon Rd
San Diego, CA 92123
Fax: 858-614-7912

Timing of Final Appeal Determinations

For Pre-Service Claims and Post-Service Claims, the Plan will act upon each request for a review of the denial of your initial appeal within the time frames indicated in the chart below:

Pre-Service Claim	Post-Service Claim
Not later than 15 days after the appeal is received.	Not later than 30 days after the appeal is received.

Notice of Determination on Final Appeal

Within the time prescribed in the "Timing of Final Appeal Determinations" section, the Plan will provide you with written notice of its decision. If the Plan determines that benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice shall state:

- The reasons for the denial, including references to specific Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.
- Any voluntary appeal procedures offered by the Plan and your right to obtain the information about those procedures.

External Review

If after exhausting the appeals process, you are still not satisfied, you have remaining remedies, such as mediation or independent External Review.

Request For External Review

Your request for external review **must be filed within four months** after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

To request an independent external review of Plan denials, visit **kp.org/cuhealthplan** and login to My Health Manager to find the External Review request form and send the written request to:

Kaiser Permanente Insurance Company – Appeals
3701 Boardman-Canfield Road
Canfield, OH 44406

You may instead fax your appeal to 614-212-7110.

Preliminary Review

Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

(c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete and the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral To Independent Review Organization

The Plan will assign an independent review organization (IRO) that is accredited by Utilization Review Accreditation Committee (URAC) or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will maintain contracts with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

Contracts between the Plan and IROs will provide for the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify the claimant and the Plan.

(d) Upon receipt of any information submitted by the claimant, the IRO will within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one

business day after making such a decision, the Plan will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable under section 2719 of the PHS Act. In addition to the document and information provided, the assigned IRO, to the extent information or documents is available and the assigned IRO considers them appropriate, the IRO will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;
- The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which will include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to the claimant and the Plan.

(g) The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or, dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the

treatment code, and its corresponding meaning, and the reason for the previous denial);

- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence of documentation, including the specific coverage provision and evidence-based standards considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable ombudsman established under the PHS Act section 2793.

(h) After a final external review decision, the IRO will retain records of all claims and notices associated with the external review process for six years; the IRO will make such records available for examination by the claimant, Plan or Federal oversight agency upon request, except where such disclosure would violate Federal privacy laws.

Reversal Of Plan's Decision

Upon receipt of a notice of a final external decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

If after exhausting of the internal Urgent Appeal process, you are still not satisfied, you may be eligible for an expedited external appeal.

Request For Expedited External Review

The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal or;

(b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant or its eligibility determination.

Referral To Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice Of Final External Review Decision

The Plan's contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the standard external review above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and Plan.

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including 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.

BINDING ARBITRATION

Arbitration Agreement for Participants and Dependents Assigned to the Kaiser Permanente Colorado Region

Those assigned to the Kaiser Permanente Colorado Region will, except for Small Claims Court cases, cases subject to a Medicare appeals procedure**,** cases subject to the Health Care Availability Act, must consent to binding arbitration under Colorado law and not lawsuit or court process, except as applicable law provides for judicial review of arbitration proceedings for any dispute between, heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Hospitals, Colorado Permanente Medical Group, P.C., or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for premises liability, or relating to the delivery of services or items, irrespective of legal theory. Participants agree to give up right to a jury trial and accept the use of binding arbitration.

CONTINUATION OF COVERAGE

What is COBRA Continuation Coverage?

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and the parallel continuation coverage requirement under the Public Health Service Act ("COBRA"), you and/or your Dependents will be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. you and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that Plan's coverage area or the Plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your termination of employment for any reason, other than gross misconduct, or
- Your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your death;
- Your divorce or legal separation;
- Your entitlement to Medicare (Part A, Part B, or both); or
- For a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred:

You, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they

are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation (unless they meet the federal definition of "qualified beneficiary"): domestic partners, same sex spouses, partners in a civil union, grandchildren (unless adopted by you), stepchildren (unless adopted by you), and children of a domestic partner/same sex spouse/partner in a civil union. However, they are eligible through your employer for continuation coverage under the same time conditions and time periods as COBRA.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; you become entitled to Medicare benefits (under Part A, Part B or both); or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA or determined by the Public Employees' Retirement Association (PERA) Disability Program Administrator, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event. To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA/PERA must determine that the disability occurred during the first 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA/PERA determination must be provided to the COBRA Plan Administrator within 60 calendar days after the date the SSA/PERA determination is made AND before the end of the initial 18-month continuation period. If the SSA/PERA later determines that the individual is no longer

disabled, you must notify the COBRA Plan Administrator within 30 days after the date the final determination is made by SSA/PERA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA/PERA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA/Continuation Coverage

COBRA/continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA/continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- when the Trust ceases to provide any group health plan, including successor plans to any employee;
- after electing COBRA/continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA/continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a preexisting condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period, the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a Member or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Kaiser's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of Kaiser's service area or Kaiser eliminates a service area in your location, you may elect to continue COBRA/continuation coverage under another CU Health Plan you are eligible for, otherwise your COBRA/continuation coverage under the Plan will be limited to emergency and urgent services only. Because the Plan does not provide out-of-

network coverage, nonemergency and non-urgent services will not be covered under the Plan outside of Kaiser's service area.

Plan Notification Requirements

The Plan, through your Employer (for the initial notification), and the COBRA Plan Administrator (for the COBRA continuation coverage election notice) is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA/continuation rights must be provided within 90 days after your (or your spouse/partner's) coverage under the Plan begins (or the Plan first becomes subject to COBRA/continuation requirements, if later).

    - If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA/continuation coverage election notice as explained below.

- A COBRA/continuation coverage election notice must be provided to you and/or your Dependents:

    - Within 44 days after loss of coverage under the Plan for your termination of employment or reduction of hours, your death, your becoming entitled to Medicare and employer bankruptcy, and

    - No later than 14 days after the end of the period in which you and/or your qualified beneficiary(ies) notify the COBRA Plan Administrator of certain other qualifying events as described below.

How to Elect COBRA/Continuation Coverage

The COBRA/continuation coverage election notice will list the individuals who are eligible for COBRA/continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA/continuation coverage. You must notify the COBRA Plan Administrator of your election no later than the due date stated on the COBRA/continuation coverage election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA/continuation coverage election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA/continuation coverage. If you reject COBRA/continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. Each qualified beneficiary has an independent right to elect COBRA/continuation coverage. COBRA/continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse or partner may elect COBRA/continuation coverage on behalf of all

the qualified beneficiaries. You are not required to elect COBRA/continuation coverage in order for your Dependents to elect COBRA/continuation coverage.

How Much Does COBRA/Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of COBRA/continuation coverage. The amount may not exceed 102% of the cost of the group health plan (including both employer and Member contributions) for coverage of a similarly situated active Member or family Member. The premium during the 11-month disability extension may not exceed 150% of the cost of the group health plan (including both employer and Member contributions) for coverage of a similarly situated active Member or family Member. For example: If the Member alone elects COBRA/continuation coverage, the Member will be charged 102% (or 150%) of the active Member premium. If the spouse or one Dependent child alone elects COBRA/continuation coverage, he or she will be charged 102% (or 150%) of the active Member premium. If more than one qualified beneficiary elects COBRA/continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA/Continuation Premiums

First payment for COBRA/continuation coverage

If you elect COBRA/continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within those 45 days, you will lose all COBRA/ continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA/continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA/continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your

coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA/continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify your employer within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period). (Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Member covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, partnership, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA/continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA/continuation coverage for the remainder of the coverage period following your early termination of COBRA/continuation coverage or due to a secondary qualifying event. COBRA/continuation coverage for your Dependent spouse and any Dependent children who are not your children (e.g., grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's or Trust's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to your employer or the Trust under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered

Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Health Coverage Tax Credit ("HCTC")

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Members who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). The Trade Adjustment Assistance Extension Act of 2011 increased the amount of the HCTC, expanded those eligible to receive it, and extended the COBRA coverage. Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the HCTC is also available at www.irs.gov by entering the keyword "HCTC". In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify your employer immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

USERRA Continuation Coverage

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you go on a qualifying military leave of absence as defined by USERRA, you may continue your coverage under the Plan for up to 24 months during the military leave to the extent required by USERRA. You must make contributions required, if any, for coverage in the manner specified by the Participant's employer. You may reinstate your coverage on return from leave to the extent required by USERRA. For more information regarding your rights and obligations under USERRA, you should contact the COBRA Plan Administrator.

MISCELLANEOUS PROVISIONS

Overpayment Recovery

Any overpayment made for Services will be recovered from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Qualified Medical Child Support Order

The Plan will provide coverage as required by any qualified medical child support order ("QMCSO"), as defined in ERISA §609(a). Your Employer has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of these procedures from your Employer.

NOTICES

Newborn Baby and Mother Protection Act

Group health plans, such as the Plan, generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). Coverage of childbirth hospital Services is subject to all provisions of this Benefits Booklet, such as the provisions concerning exclusions, Copayments, and Coinsurance.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21, 1998. This Federal law requires all group health plans that provide coverage for a mastectomy must also provide coverage for the following Services:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

The Plan provides coverage for mastectomies and related Services. Coverage is subject to all provisions of this Benefits Booklet, such as the provisions concerning exclusions, Copayments, and Coinsurance.

SERVICES AREAS

Participants must live in a Kaiser Service Area at the time of enrollment. You cannot continue enrollment as a Participant if you move outside a Kaiser Permanente Service Area. To verify if your home or work address is within the Kaiser Service Area, check kp.org.

SUMMARY CHART

This section summarizes Cost Sharing and benefit limits such as day limits, visit limits and benefit maximums. It does not describe all the details of your benefits. To learn what is covered for each benefit (including exclusions and limitations), please refer to the identical heading in the "Benefits and Cost Sharing" section and to the "General Exclusions and Limitations" section of this Benefits Booklet.

University of Colorado Health and Welfare Plan Effective Date: 7/1/2016 This is a Summary of Benefits for your Kaiser Permanente EPO Plan		
OVERALL PLAN FEATURES		
Plan Accumulation Type	Plan Year	
Plan Year Out-of-Pocket Maximum Per Person Per Family	 **$6,850** **$13,700**	
Each family member has an individual Out-of-Pocket Maximum amount within the family Out-of-Pocket Maximum. The individual cannot contribute to the family Out-of-Pocket Maximum more than the amount of a single Out-of-Pocket Maximum.		
Copayments: One Copayment per provider is charged per day.		
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.		
ROUTINE PREVENTIVE EXAMS AND SERVICES See Kaiser Permanente Colorado Health Care Reform Preventive Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Kaiser Permanente Colorado Health Care Reform Preventive section are treated the same as non-preventive Lab and X-ray Services. Frequency and Age Limits managed by Network Provider except where noted.		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Wellness Exams – Adults (Including *Well Woman*) Includes vision and hearing screenings. See Vision Refraction Exam for refractions and Hearing Exams for audiologic testing.	**$0**	**N/A**
Wellness Exams – Children Includes vision and hearing screenings. See Vision Refraction Exam for refractions and Hearing Exams for audiologic testing.	**$0**	**N/A**
Preventive Screenings Applies to Adults and Children.	**$0**	**N/A**
Immunizations (Preventive) Applies to Adults and Children.	**$0**	**N/A**
OUTPATIENT SERVICES (Office or Outpatient Facility) Primary Care Cost Share will be charged for Family Practice, General Internal Medicine and General Pediatrics specialties. Specialty Care Cost Share will be charged for visits with all other medical specialties.		
Office Visits Office Visit Office Visit	 **$30** Primary Care **$40** Specialty Care	 **Yes** **Yes**
Allergy Office Visit Injection as part of an Office Visit (Includes serum) Injection only (administration and materials) Testing	 **$40** **$0** **$10** **$40**	 **Yes** **N/A** **Yes** **Yes**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Biofeedback Services Medical and Mental Health Services		
Mental Health provider	**$30** Primary Care	**Yes**
Medical Services provider	**$40** Specialty Care	**Yes**
Cardiac Rehab	**$30** Primary Care	**Yes**
	$40 Specialty Care	**Yes**
Chemotherapy Services		
Office Visit	**$40**	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Dermatology		
Ultraviolet light treatment	**$30** Primary Care	**Yes**
All other dermatology services	**$40** Specialty Care	**Yes**
Dialysis Services	**$40**	**Yes**
Family Planning		
Office Visit	**$30** Primary Care	**Yes**
Office Visit	**$40** Specialty Care	**Yes**
Contraceptive counseling, implantable or injectable Contraceptives and related office visit charges	**$0**	**N/A**
Health Education Health education visits are covered for all diagnoses. Applicable Office Visit Cost Share based on provider type.		
Office Visit	**$30** Primary Care	**Yes**
Office Visit	**$40** Specialty Care	**Yes**
Hearing Exam Audiometry exam and medical exam		
Audiologist	**$30** Primary Care	**Yes**
Otolaryngologist	**$40** Specialty Care	**Yes**
House Calls	**$30** Primary Care	**Yes**
	$40 Specialty Care	**Yes**
Infusion Services Requires skilled or medical administration.		
Office Visit	**$30** Primary Care	**Yes**
Office Visit	**$40** Specialty Care	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Injections and Immunizations Non-routine		
Office Visit	**$30** Primary Care	**Yes**
Office Visit	**$40** Specialty Care	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Epidural Steroid Injections	**$250** per visit	**Yes**
Travel Immunizations		
Office Visit	**$30** Primary Care	**Yes**
Office Visit	**$40** Specialty Care	**Yes**
Provided during an Office Visit	**$0**	**N/A**
Nutrition Visits		
Office Visit	**$30** Primary Care	**Yes**
Office Visit	**$40** Specialty Care	**Yes**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Pulmonary Rehab Limits	**$5** Initial evaluation and up to 6 education sessions, up to 12 exercise sessions and a final evaluation to be completed within a 2-3 month period. Participation in a pulmonary rehab program is limited to once per lifetime.	**Yes** **N/A**
Radiation Therapy	**$40**	**Yes**
Respiratory Therapy	**$40**	**Yes**
Vision Refraction Exam NOTE: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty	**$30 Optometrist** **$40 Ophthalmologist**	**Yes** **Yes**
HOSPITAL / SURGERY SERVICES		
Inpatient Hospital Includes room and board for semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Medically Necessary Private Duty Nursing, Ancillary Services, Supplies. Additional cost for private rooms is not covered unless Medically Necessary. Per day Per day Cost Share limits	 **$250** **$1,000** per admission	 **Yes** **Yes**
Ambulance Emergency Ground and Air Ambulance Scheduled Ground Ambulance Non-Network Hospital to Network hospital (repatriation)	 **$0** **$0** **$0**	 **N/A** **N/A** **N/A**
Emergency Services Accident and Illness. High cost radiology procedure Cost Share is applied in addition to ED Cost Share Copayment waived if admitted.	**$150** **Yes**	**Yes** **N/A**
Urgent and After Hours Care Urgent Care and After Hours settings	**$30**	**Yes**
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center. Cost Share also applies to these surgeries provided at KPCO medical clinics: Endovenous Ablation with Radiofrequency, Transuretheral Microwave Therapy, Endometrial Ablation with Hysteroscopy, Fistulization Sclera (Trabiculectomy with Mytomycin) Colonoscopy	**$250** per visit **$0**	**Yes** **N/A**
Abortion Medically Necessary. Excludes Elective procedures. Office Visit Office Visit Outpatient Surgery Inpatient Hospital per day Inpatient Hospital per day Cost Share limits	 **$30** Primary Care **$40** Specialty Care **$250** per visit **$250** per day **$1,000** per admission	 **Yes** **Yes** **Yes** **Yes** **Yes**
Bariatric Surgery Office Visit Outpatient Surgery Inpatient Hospital per day	 **$40** Specialty Care **30%** **30%**	 **Yes** **Yes** **Yes**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Temporomandibular Surgery (TMD/TMJ)		
Office Visit	**$40** Specialty Care	**Yes**
Outpatient Surgery	**$250** per visit	**Yes**
Inpatient Hospital per day	**$250** per day	**Yes**
Inpatient Hospital per day Cost Share limits	**$1,000** per admission	**Yes**
Organ Transplants Organ acquisition, diagnostic testing for donor and recipient		
Office Visit	**$40** Specialty Care	**Yes**
Outpatient Surgery	**$250** per visit	**Yes**
Inpatient Hospital per day	**$250** per day	**Yes**
Inpatient Hospital per day Cost Share limits	**$1,000** per admission	**Yes**
Travel and Lodging for Organ Transplants Includes coverage for recipient, care-giver and donor for transportation, lodging and daily expenses. Daily expenses include incidental expenses such as meals and does not include personal expenses.	Travel, lodging and daily expense limits, as well as reimbursements are coordinated and determined by the regional Transplant Coordinator.	**N/A**
MATERNITY		
Routine Pre-Natal and Post-Partum Care		
Pre-natal and first post-partum visit	**$0**	**N/A**
Home Perinatology Visits	**$30** Primary Care	**Yes**
	$40 Specialty Care	**Yes**
Hospital Inpatient Includes contracted Birthing Center if available		
Per day	**$250**	**Yes**
Per day Cost Share limits	**$1,000** per admission	**Yes**
DIAGNOSTIC TESTS & PROCEDURES Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings: These Services are treated the same as Lab and X-ray Services in this section.		
Diagnostic Lab	**$0**	**N/A**
Diagnostic X-ray	**$0**	**N/A**
Diagnostic Tests performed in the Office	**$30** Primary Care	**Yes**
	$40 Specialty Care	**Yes**
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine and PET	**$100** per procedure	**Yes**
INFERTILITY SERVICES Services to rule out the underlying medical causes of Infertility are part of the medical benefit. Further diagnosis and treatment of Infertility after initial diagnosis is made will be considered treatment of infertility. Covered treatments include Artificial Insemination and Surgery. GIFT/ZIFT and IVF are not covered.		
Hospital Charges		
Per day	**50%**	**Yes**
Office Visit	**50%**	**Yes**
Diagnostic Lab & X-ray	**50%**	**Yes**
Outpatient hospital or Ambulatory Surgery Center (ASC)	**50%**	**Yes**

MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES Includes Marriage Counseling		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Mental Health - Inpatient Includes Residential Treatment		-
Per day	**$250**	**Yes**
Per day Cost Share limits	**$1000** per admission	**Yes**
Partial Hospitalization		
Per day	**$30**	**Yes**
Mental Health - Intensive Outpatient Includes all Services provided during the day	**$30** per day	**Yes**
Mental Health – Outpatient/Office Cost share may also apply to office visits with MH/CD diagnoses.		
Individual Visit Cost Share	**$30** per day	**Yes**
Group Visit Cost Share	**$15** per day	**Yes**
Treatment of Autism Spectrum Disorders	Same as other similar Services	Same as other similar Services
Limits: Plan year Benefit Maximum for Applied Behavior Analysis (ABA).		**N/A**
Birth through age 8	**550 visits per plan year**	**N/A**
Age 9 through 18	**185 visits per plan year**	
Note: There must be a diagnosis of ASD for benefits to apply toward the maximum benefit amount.		
Chemical Dependency - Inpatient Detox covered under-medical benefits. – Includes Residential Treatment		
Per day	**$250** per day	**Yes**
Per day Cost Share limits	**$1000** per admission	**Yes**
Chemical Dependency - Partial Hospitalization		
Per day	**$30** per day	**Yes**
Chemical Dependency - Intensive Outpatient Includes all Services provided during the day.	**$30** per day	**Yes**
Chemical Dependency – Outpatient/Office Cost share may also apply to office visits with MH/CD diagnoses.		
Individual Visit Cost Share	**$30** per day	**Yes**
Group Visit Cost Share	**$15** per day	**Yes**
MULTIDISCIPLINARY REHABILITATION - Organized multidisciplinary Service program in a designated or Skilled Nursing Facility.		
Inpatient Hospital		
Per day	**$250** per day	**Yes**
Per day Cost Share limits	**$1000** per admission	**Yes**
Outpatient Rehab Therapy	**$30** per day	**Yes**
Limits	**None**	**N/A**
PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES - Outpatient Cost Share for therapies is applied on a one Copayment per provider per day basis.		
Physical Therapy	**$30**	**Yes**
Visit Maximum	20 visits per Plan year*	**N/A**
Visit limits do not apply for the treatment of autism		

Benefit Type	You Pay and/or Maximums	Applies to OOP
Occupational Therapy	**$30**	**Yes**
Visit Maximum	20 visits per Plan year*	**N/A**
Visit limits do not apply for the treatment of autism		
Speech Therapy	**$30**	**Yes**
Visit Maximum	20 visits per Plan year*	**N/A**
Visit limits do not apply for the treatment of autism		
*No visit limits through Age 18 apply for diagnosis of ASD. Visit limits apply to Members eligible for Early Intervention Services after separate EIS visits are exhausted.		
EARLY INTERVENTION SERVICES (EIS) Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for Early Intervention Services (EIS).		
Physical/Speech/Occupational Therapy	**$0**	**N/A**
Plan year maximum combined with social, educational, nutritional and other Services.	**55 visits per plan year**	**N/A**
SKILLED CARE		
Home Health Care	**$0**	**N/A**
Visit definition: 28 hours per week combined over any number of days per week and furnished less than eight (8) hours per day. Additional time up to 35 hours per week but fewer than eight (8) hours per day may be Authorized on a case-by-case basis.		
Visit Maximum	**unlimited**	**N/A**
Home Infusion Infusion materials, drugs and supplies	**$0**	**N/A**
Hospice		
Hospital Inpatient	**$0**	**N/A**
Home Based	**$0**	**N/A**
Hospice Special Services Program		
Respite Services- Home Based	**$0**	**N/A**
Respite Services- Hospital Inpatient	**$0**	**N/A**
Skilled Nursing Facility		
Per day	**$0**	**N/A**
Day Maximum	100 days per Plan year	**N/A**
OTHER SERVICES		
Acupuncture Self referred visits	**$30**	**N/A**
Visit Maximum	20 visits per contract year combined with Chiropractic	**N/A**
Chiropractic Care Self referred visits with a Network or contracted provider	**$30**	**Yes**
Visit Maximum	20 visits per Plan year	**N/A**
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury	**Not covered**	**N/A**
Durable Medical Equipment	**$0**	**N/A**
Colorado DME/P&O formulary applies		**N/A**
Breast Feeding Pump	**$0**	**N/A**
Oxygen	**$0**	**N/A**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Prosthetics and Orthotics Includes colostomy/ostomy and urological supplies.	**$0**	**N/A**
Out of Area Student Benefit: Coverage Outside the Service Area (within the U.S.)	**See Below**	**N/A**
Office Visit limits (office procedures. labs, PT?OT?ST, and Allergy Injections are excluded)	**$30 copay** **5 per** plan year	**N/A**
Diagnostic X-ray Service limits (X-ray and Ultrasound only)	**20%** **5 per** plan year	**N/A**
Prescription Drug	**Applicable RX copay** **$15 Generic /$35 Brand**	
Hearing Aids - Initial and replacement hearing aids for minor children with a verified hearing loss.	**$0**	**N/A**
Age Limits	Persons under age of 18 years	**N/A**
Benefit Limits	One hearing aid for each ear every 60 months unless alterations to existing hearing aid cannot adequately meet the needs of the child	**N/A**
Vision Hardware - Contact Lenses Fitting exam is not covered. Medically Necessary Eyewear.	Not covered	**N/A**
Vision Hardware - Frames and Eyeglass Lenses	Not covered	**N/A**
OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified		
2 Tier		
Generic	$15 up to 30 day supply	**Yes**
Specialty Rx	**20**% for specialty Rx, including Self-Administered injectables, up to a maximum of $75 per Rx, up to 30 day supply	**Yes**
Brand	$35 up to 30 day supply	**Yes**
Mail Order Drugs		-
2 Tier Mail Order		-
Generic	$15 up to 30 day supply and $30 from 31 up to 90 day supply	**Yes**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Specialty Rx	**20**% for specialty Rx, including Self-Administered injectables, up to a maximum of $75 per Rx, up to 30 day supply	**Yes**
Brand	$35 up to 30 day supply and $70 from 31 up to 90 day supply	**Yes**
Blood Factors	**$0**	**N/A**
Diabetic Coverage		
Oral Medications and Insulin	**$0**	**N/A**
Diabetic testing supplies (meters, test strips)	**$0**	**N/A**
Diabetic administration devices (syringes)	**$0**	**N/A**
Special Oral Foods Amino acid modified products	$3.00 per product per day for formula.	**No**
Infertility Drug Coverage	**Not covered**	**N/A**
Growth Hormone	Generic: $15 up to 30 day supply Brand: $35 up to 30 day supply	**Yes**
Sexual Dysfunction	**Not covered**	**N/A**
Smoking Cessation	**$0**	**N/A**
Weight Loss	**Not covered**	**N/A**
ACA Mandated OTC Drugs*		
Aspirin	**$0**	**N/A**
Oral Fluoride	**$0**	**N/A**
Folic Acid	**$0**	**N/A**
Iron Supplements	**$0**	**N/A**
Vitamin D	**$0**	**N/A**
Female Contraceptives (spermicides, female condoms and sponges)	**$0**	**N/A**
Contraceptive Devices (diaphragms, cervical caps, etc.) **and Contraceptive Drugs**	**$0**	**N/A**
Emergency Contraception*	**$0**	**N/A**
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) office visit Cost Share for administration may apply.		
* With prescription, no cost share. Without prescription, Participant pays retail cost		