

Funded by the University of Colorado Health and Welfare Trust



Health Plan
Kaiser

A guide to your benefits

2026-27



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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.

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 1-877-883-6698
TTY 1-877-870-0283

Utilization Management for Out-of-Network Emergency Services

Colorado Region 303-338-3800

Advice Nurses

Colorado Region 1-866-311-4464

Interpreter Services

Colorado Region 1-877-883-6698

Pharmacy Benefit Information

Colorado 1-866-427-7701

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.
- The Plan’s determination as to whether the Plan is complying with the non-quantitative treatment limitation parity provision of the Mental Health Parity and Addiction Equity Act.
- Plan determinations that involve plan compliance with surprise billing and cost-sharing protections under the Federal No Surprises Act.

Allowable Amount: The amount the provider has contracted to accept for Services rendered. This amount is based on a case rate for bundled professional and facility Services, a contract rate or a network fee schedule. In the case of pharmaceuticals, the Allowable Amount is an amount based on the average wholesale price plus a dispensing fee.

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

Ancillary Service: Services that are:

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

Claims Administrator: Kaiser Permanente Insurance Company (KPIC) is the self-funded Claims Administrator. You can find the Claims Administrator’s address in the “Customer Service Phone Numbers” section and on your Kaiser Permanente ID card.

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 as described in the “Schedule of Benefits” section.

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

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

Copayment or Copay: A specified dollar amount that you must pay for certain Covered Services as described in the “Schedule of Benefits” section.

Cost Sharing: Copayments, Coinsurance and Deductibles and any other amounts that you must pay for Covered Services.

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

Custodial Care: Any Service, procedure or supply that is provided primarily:

- For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury
- To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel

Such Services and supplies are regarded as Custodial Care without regard to the following:

- Who prescribes the Service and supplies
- Who recommends the Service and supplies
- Who performs the Service or the method in which such Services are performed

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 Employer's requirements for eligibility. A dependent includes a Spouse/Partner, as defined by the Employer. This Benefits Booklet sometimes refers to a Dependent or Participant as “you.” See the “Eligibility” section for more information regarding Grandchildren.

Domestic Partner: A person registered as a Participant's domestic partner with a state or local government.

Durable Medical Equipment (DME): Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all 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 Covered Services provided by Kaiser Permanente providers, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for Services provided to participants.
- For Covered Services that Network Providers (other than Kaiser Permanente providers) 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 that are covered under the Plan and 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 provided by Network Providers, 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.
- For Emergency Services and scheduled Services at a Network Hospital or ambulatory surgical center rendered by Non-Network Providers, the amount owed pursuant to federal law.
- For all other Services provided by Non-Network Providers, the amount to which the Non-Network Provider agrees to accept for such Covered Services.
- Cost sharing will be calculated based on the Eligible Charges for such Covered Services.

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 person, the health of the pregnant person or the unborn child) in serious jeopardy
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themselves or to others

- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: Means Services that are Medically Necessary to treat an Emergency Medical Condition:

- A medical screening examination (as required under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)) and stabilization Services that are within the capability of the emergency department of a hospital or Independent Freestanding Emergency Department, including professional and ancillary Services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Post Stabilization Services and outpatient observation during the same “visit” unless the provider/facility (1) determines you may travel using nonmedical or nonemergency medical transportation; and (2) has obtained informed consent from you for such items/Services (Consent by may not be obtained when Services are unforeseen and urgent. Ancillary providers may never seek consent to bill the enrollee). In addition, if you (or your authorized representative) consent to the provision of Services by a non- Network Provider, then KPIC will not pay for such Services and the amount you pay will not count toward satisfaction of the Annual Deductible, if any, or the Out-of-Pocket Maximum(s).

EMTALA: The Emergency Medical Treatment and Labor Act (EMTALA) is a United States Congressional Act passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer: University of Colorado and University of Colorado Medicine.

Exclusive Provider Organization (EPO): A health care plan design that requires the use of a specific network of health care providers for all but emergency and out-of-area urgent care Services.

Experimental and Investigational: Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in, or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigational if the Claims Administrator determines that one or more of the following criteria apply when the Service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any Service not deemed Experimental/Investigational based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational.

Family: A Participant and all their Dependents.

Hearing Aid: An electronic device You wear for 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.

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

Kaiser Permanente (KP): A Network of Providers that operates 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 Washington for the Washington Region

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

Medically Necessary: A Service is Medically Necessary if, in the judgment of Kaiser Permanente, it meets all 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 aged 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 visit www.kp.org or call Customer

Service at the number listed in the “Customer Service Phone Numbers” section. To find a Kaiser Pharmacy visit www.kp.org - select *Pharmacy*.

Network Facility: Any outpatient or inpatient medical facility listed on www.kp.org. Facilities house medical suites, critical care, laboratory imaging and telemedicine Services, ambulatory surgery and pre- and post-operative Services. **Note:** Facilities are subject to change at any time. For the current locations, call Customer Service.

Network Hospital: A licensed hospital (that provides inpatient, outpatient and ambulatory surgical care and other related Services for surgery, acute medical conditions, or injuries usually for a short-term illness or condition), owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services.

Network Optical Sales Office: An optical sales office owned and operated (or designated) by Kaiser Permanente. Please refer to www.kp.org for a list of Plan Optical Sales Offices in your area. Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please go to www.kp.org or call the Customer Service phone number listed under “Customer Service Phone Numbers” in the “Legal and Administrative Information” section.

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 Ancillary Providers: Non-MD providers such as Psychologists, MFCCs, LCSWs, Optometrists, Physical, Speech, and Occupational Therapy. Such providers will be subject to the primary care Cost Share, however, verify referral requirements in the “How to Obtain Services” section.

Network Primary Care Provider: Family Practice, Internal Medicine, and Pediatrics. **Note:** Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based on the supervising physicians’ provider status.

Network Specialist: Medical Doctor with a specialty not considered primary care. **Note:** Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based on the supervising physicians’ provider status.

Medical Group: The following medical groups for the following Kaiser Permanente Regions:

- The Permanente Medical Group for the Northern California Region
- The Southern California Permanente Medical Group for the Southern California Region
- Colorado Permanente Medical Group, P.C., for the Colorado Region

- The Southeast Permanente Medical Group, Inc., for the Georgia Region
- Hawaii Permanente Medical Group, Inc., for the Hawaii Region
- Mid-Atlantic Permanente Medical Group, P.C., for the Mid-Atlantic States Region
- Northwest Permanente, P.C., Physicians & Surgeons, for the Northwest Region
- Washington Permanente Medical Group, P.C.

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 if it continues to meet the definition.

Non-Network Provider or Out-of-Network Provider: Any health care 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 and Deductible 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 "Legal and Administrative Information" section.

Plan Document: A comprehensive written instrument which sets for the rights of the plan's participants and beneficiaries. It sets forth what benefits are available, who is eligible, how benefits are funded, who is the named fiduciary, how the plan can be amended and the procedures for allocating plan responsibilities.

Plan Sponsor: The Regents of the University of Colorado.

Plan Year: The date span (Plan begin and end dates) listed in the "Legal and Administrative Information" section.

Post Stabilization Services: Means Medically Necessary Services related to your Emergency Medical Condition you receive after your treating physician determines your Emergency Medical Condition is Stabilized. Post-Stabilization Services are covered only when (1) they are considered to be Emergency Services under federal law (without Prior Authorization) or (2) KPIC determines such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service.

Primary Care: Covered Services provided by s Network Primary Care Provider.

Prior Authorization: Approval obtained in advance which is required for certain Services to be Covered Services under the Plan. Prior 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 movable 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.

Self-Funded Medical Plan: An arrangement in which the employer assumes the financial risk for providing health care benefits to enrolled employees and dependents. Instead of paying a fixed premium to an insurance carrier or HMO, the employer pays health care claims out of its own pocket as the claims are incurred. Claims are usually processed through a third-party administrator.

Services: Healthcare, including mental health care, Services and items. Health care services, treatments, procedures, and items, including mental health care and behavioral health treatment to treat pervasive developmental disorders or autism

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: The person to whom you are legally married under applicable law.

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

State of Emergency: During a national or regional state of emergency patient care may be handled in a variety of new and unusual locations (i.e., Drive up testing in parking lots, overflow inpatient care in convention centers, floating military hospitals and reopened

previously closed facilities). Payment for Services rendered by licensed providers will be based on provider licensure rather than place of Service.

Summary Plan Description (SPD): An ERISA-required document which conveys the plan information in an understandable summary.

Surprise Billing: Billing by a Non-Network Provider (except when you have consented) for 1) Emergency Services, 2) certain other Services performed by a Non-Network Provider at a Network facility and 3) air ambulance Services from a Non-Network Provider that is prohibited under federal law. When Surprise Billing occurs, you are only required to pay the cost-sharing amount for services provided by a Network Provider.

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 Employee/Participant must live or work in the 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 within the Kaiser Colorado Service Area as identified on www.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.

Eligibility is defined by the employer as defined in Appendix II of the University of Colorado Health and Welfare Plan, found at www.becolorado.org/trust. The employee 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:

- **Spouse/Partner**, as defined by the Employer.
- **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 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 childcare 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. ***Services provided during the first 31 days of coverage may be 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 15th, 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), 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 partner's 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, continually enrolled, 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.** After the first 31 days of life, 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 Spouses and Dependents.

- University of Colorado – Employee Services
- University of Colorado Medicine – 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 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 30 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 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 your 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.
- 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 any person or property at a Network Provider office or Facility.
- (2) Commit(s) theft from a Network Provider or 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.

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 Employer notifies Kaiser Permanente 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

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 will be responsible for Services provided after your benefits have been terminated.

The Trust 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 must receive all Covered Services from Network Providers, except where specifically noted in the “Emergency Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section

The Kaiser Permanente medical care program gives you access to all 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.

For information about Urgent Care outside the Service Area, please refer to the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section.

Advice Nurses

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the advice nurse phone number listed in the “Customer Service Phone Numbers” section. When you call, a trained support person may ask you questions to help determine how to direct your call.

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. You can change your Personal Network Physician for any reason.

Kaiser Permanente (KP) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, KP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Customer Service or log onto www.kp.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from KP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain Services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service at the number on the back of your ID card.

Telemedicine

Interactive visits between you and your Personal Network Physician using phone, interactive video, internet messaging applications, Click-to-Chat instant messaging and email are intended to make it more convenient for you to receive medically appropriate Covered Services. When available, you may receive Covered Telemedicine Services listed under the Benefits and Cost Sharing section, subject to the “General Limitations, Coordination of Benefits, and Reductions” section. You are not required to use Telemedicine Services, but if you do, plan deductible may apply. <https://about.kaiserpermanente.org/our-story/our-care/is-telehealth-right-for-you>

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.

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. 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.

Self-Referrals

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

- Your Personal Network Physician
- Network Generalists in internal medicine, pediatrics, and family practice

- Network 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.

Prior Authorizations

Certain Services may require Prior Authorization for the Plan to cover them. Your Network Physician will request Prior Authorization when it is required, except that you must request Prior Authorization to receive covered Post-Stabilization Care from Non-Network Providers, as described in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section.

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 for which the referral is valid and the Services Authorized.

The following are examples of Services that may require Prior Authorization: All inpatient and outpatient facility Services (excluding emergencies)

- Office based habilitative /rehabilitative care: 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

Note: Prior Authorization requirements are based on the region in which you are receiving services. For care received in a Kaiser Permanente facility or by Kaiser Permanente providers, authorization is managed by your physician and a component of your physician’s referral within the Kaiser system. For care received outside a Kaiser Permanente facility or by non-Kaiser Permanente providers, your physician will request Prior Authorization and/or referral for care.

For more information about Prior Authorization for your region visit your regional Utilization Management site.

Colorado:

<https://healthy.kaiserpermanente.org/colorado/pages/utilization-management>.

Step Therapy

Step-therapy is a protocol that may apply to certain Services including but not limited to or prescription drugs that requires a SF Member to use a lower level of treatment, or generic or other brand drug first prior to the more intensive treatment or prescribed drug. If the different Covered Service or other prescription drug is not effective, then the Plan will cover a higher level of treatment or different drug. If lower level of treatment is not necessary, appropriate, and feasible, the decision will be based upon the Participants individual medical need(s).

If the Plan denies a Service or prescription drug because Prior Authorization was not obtained, or if a step-therapy exception request is denied, you may submit an appeal to obtain coverage. For information on how to submit an appeal, see the “Claims and Appeals” section.

Second Opinions

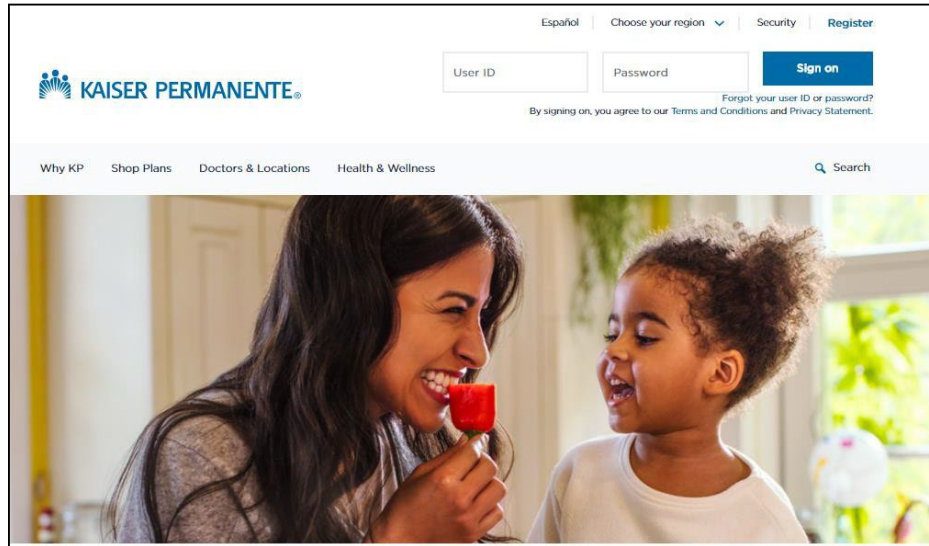
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may obtain a second opinion from:

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

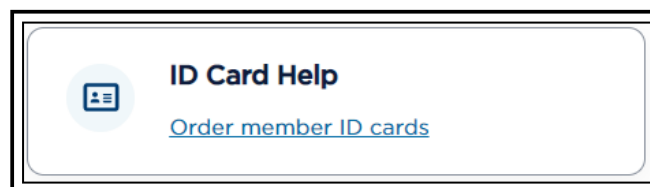
Your Identification Card

Your Kaiser Permanente identification card (ID card) has a medical or health record number on it, which you will need when you call for advice, make an appointment, or go to a provider for Covered Services. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical or health record number is used to identify your medical records and coverage information.

Your ID card is for identification only. 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 they receive, and the amount billed may be different from the Eligible Charges for the Services.



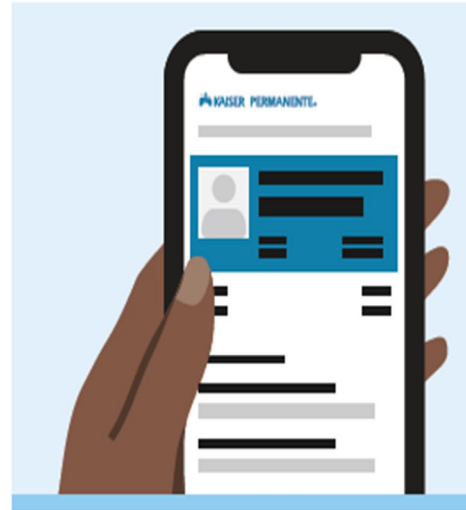
To print a temporary card or replace your Kaiser Permanente ID card, log onto kp.org, select the Coverage and Costs menu. Then select the Coverage and Costs menu and the ID Card help option.



In line with federal requirements, your Kaiser Permanente ID card contains information about some of your benefits and costs, such as your deductible and out-of-pocket maximum.

Download a Digital ID Card

1. If you haven't already done so, create your online account at www.kp.org/registernow. You can also create your online account in the Kaiser Permanente app.
2. Go to your app store and download the Kaiser Permanente app to your mobile device.
3. Sign into the app using your kp.org account information.
4. Once you sign into the app, look for the "Member ID Card" icon to see your updated ID card. You can show your digital ID card to check in for appointments, pick up prescriptions, and more.



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. However, if you are visiting in the Service Area of another Kaiser Permanente Region, you will also be able to receive Services from Network Providers in that Region. Referrals or Prior Authorization may differ among Regions. For information about Network Providers in other Kaiser Permanente Regions, please call customer Service.

For 24/7 travel support Anytime, anywhere, call the Away from Home Travel Line at **951-268-3900** or visit www.kp.org/travel.

Moving Outside of the Service Area

If you move to an area not within a Colorado Kaiser Permanente Service Area, you will be required to change your health plan to one that serves your area. Please contact your employer for instructions.

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 Number](#)" 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 at the number listed in the "[Customer Service Phone Number](#)" section.

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).

For current locations of Network facilities please visit www.kp.org or call Customer Service at the number listed in the “Customer Service Phone Numbers” section. To find a Kaiser Pharmacy visit www.kp.org - select *Pharmacy*.

Network Facilities for your area are listed in greater detail on www.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 Services, (including Post-Stabilization Services, 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 following requirements:

- Emergency Services are covered if the Emergency Services would be covered if you received the care from a Network Provider. You do not need to get Prior Authorization from Kaiser Permanente to receive Emergency Services (from the nearest hospital emergency department or Independent Freestanding Emergency Department) or Urgent Care outside the Service Area from non–Network Providers.
- Post Stabilization Services that are part of the same visit for Emergency Services are covered until your attending emergency physician determines you are able to travel (using non- medical/non-emergency medical transportation), to a Network facility within a reasonable distance considering your medical condition.

Emergency Services

If you have an Emergency Medical Condition, (see definition in the “[Definitions](#)” section), call 911 (where available) or go to the nearest hospital emergency department, independent freestanding emergency department or Urgent Care clinic licensed to provide Emergency Services. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive anywhere in the world, subject to the “[General Exclusions and Limitations](#)” section.

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 are admitted to a Non-Network hospital as a part of the same visit for you Emergency Medical Condition your stay will be covered as Emergency Services. Otherwise, your stay will be covered only if Kaiser Permanente is notified within 24hours or as soon as reasonably possible after stabilization of your condition.

Post-Stabilization Services

Post-Stabilization Services (including observation care) are Medically Necessary and related to your Emergency Medical Condition when they are a part of the same visit for screening and stabilization of your Emergency Medical Condition. Post-Stabilization Services also includes Medically Necessary Covered Durable Medical Equipment after discharged from a hospital and related to the same Emergency Medical Condition. For information on covered Durable Medical Equipment see the “[Durable Medical Equipment \(DME\), External Prosthetics and Orthotics](#)” section. Post-Stabilization Services received from a Non–Network Provider, including inpatient care at a non–Network Hospital, is covered until:

- Your attending emergency physician determines you are able to travel using non-medical/non-emergency medical transportation;
- There is an available Network facility within a reasonable distance considering your medical condition.

Note: You will be responsible for any Services that you consent to pay once your attending

physician determines you are in a condition to provide voluntary consent; and

- The Non-Network provider/facility satisfies an enhanced notice and consent process whereby you accept liability for the Services;
- Your attending physician determinations are binding on the facility.
- Giving informed consent does not bind the Plan in any way to cover Post Stabilization Services; the provider should contact Kaiser Permanente to coordinate care.

To request Prior Authorization to receive additional Services 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. A Kaiser Permanente representative will then discuss your condition with the Non–Network Provider. If Kaiser Permanente decides that you require additional services and that the Services 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 normally be covered (under “[Ambulance Services](#)” in the “[Benefits and Cost Sharing](#)” section) had a Network Provider provided them.

Be sure to ask the Non–Network Provider to tell you what Services (including any transportation) Kaiser Permanente has authorized, because once your attending emergency physician determines you are able to travel using non-medical/non- emergency medical transportation and there is a Network facility within a reasonable distance considering your medical condition, then any additional Services and/or related transportation provided by Non–Network Providers is not covered unless authorized by Kaiser Permanente.

Urgent Care

Within the Service Area

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 are in the Service Area and think you may need urgent care, call the urgent care or advice nurse telephone number (see “[Customer Service Phone Numbers](#)” section or sign on to **the** members.kp.org website).

The following Services are not covered under this section:

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

Note: Urgent Care received in a Kaiser Permanente Region from a Non-Network emergency department is not covered, except prior authorized Durable Medical Equipment related to Urgent care you received outside the Service Area.

Out-of-Area Urgent Care <http://kp.org/travel>



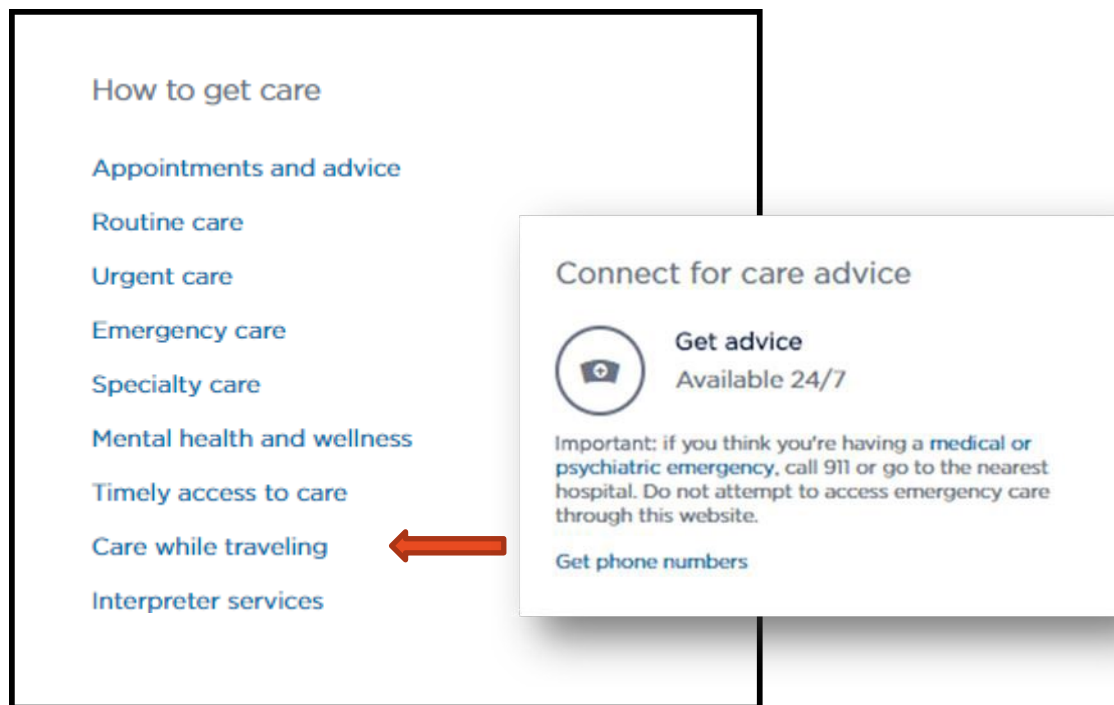
- For **Nonurgent** care you can always schedule in-person visits in states with Kaiser Permanente facilities or use kp.org or the Kaiser Permanente app across the U.S to get 24/7 care and advice from Kaiser Permanente clinicians by phone or online.
- You may also seek **Urgent** care at The Little Clinics (TLC) MinuteClinic®, Concentra, or any other urgent care facility outside a state where Kaiser Permanente operates. If you get care at MinuteClinic®, TLC or Concentra outside a state where Kaiser Permanente operates, you'll be charged your standard copay or co-insurance.
- Note: Urgent Care received in Kaiser Permanente [Service Areas](#) from a Non-Network Provider or emergency department is not covered.

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 the following are true:

- You receive the Services from Non-Network Providers while you are temporarily outside the Service Area;
- The care cannot be delayed until you return to our Service Area; and
- 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.

Follow-up care from a Non-Network urgent care provider is not covered, except prior authorized Durable Medical Equipment related to Urgent care you received outside the Service Area.

Note: Urgent Care received in Kaiser Permanente [Service Areas](#) from a Non-Network Provider or emergency department is not covered.



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, (including Post-Stabilization Services), or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition.
- Emergency Services and Urgent Care you receive from Network Providers.

Payment and Reimbursement

If you receive Emergency Services or Urgent Care outside the Service Area from a Non–Network Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. To request payment or reimbursement, you must file a claim as described in the "Claims and Appeals" section.

Cost Sharing

The Cost Sharing for Emergency Services and Urgent Care outside the Service Area that you receive from a Non–Network Provider is the Cost Sharing required for the same Services provided by a Network Provider as described in the "Summary Chart" section. Your required Cost Sharing will be subtracted from any payment made to you or the Non–Network Provider.

- If you receive Emergency Services in the Emergency Department of a Non- Network Hospital you pay the Cost Share for an Emergency Department visit.
- If you received inpatient or outpatient Post-Stabilization Services in a Non-Network Hospital, you pay the Cost Share for hospital inpatient care.
- If you were given Prior Authorization for Durable Medical Equipment necessary for discharge from a Non-Network Hospital, you pay the Cost Share for Durable Medical Equipment.

Out-of-Area Benefit Non-Urgent or Emergency Care (dependents only)

A limited benefit is available to Dependents who are outside the Denver/Boulder, Northern Colorado or Southern Colorado Service Area. The out-of-area 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.

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 or Urgent Services) are not covered under the Out-of-Area Student Benefit.

BENEFITS AND COST SHARING

The only Services that are covered under this Plan are those listed as covered in the “**Benefits and Cost Sharing.**” section, subject to the exclusions and limitations described in this “**Benefits and Cost Sharing.**” section and all provisions in the “**General Exclusions, General Limitations, Coordination of Benefits, and Reductions.**” 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, General Limitations, Coordination of Benefits, and Reductions.**” 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, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers**” section or the “**How to Obtain Services**” section; and
- 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 (and associated Ancillary Services) as described under “Referrals” and “Self Referrals” in the “**How to Obtain Services.**” section;
 - Emergency Services and Out-of-Area Urgent Care as described in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Prov” section;
 - Care received outside the Service Area as described in the “**Receiving Care in Other Kaiser Permanente Regions**” section; or
 - Emergency ambulance Service as described under “Ambulance Services in this “**Benefits and Cost Sharing**” section.

Note: Non-Network Providers may provide a notice and consent form seeking your (or your authorized representative’s) agreement that you will owe the full cost of the bill for the items and Services that the Non-Network Provider furnishes. If you (or your Authorized Representative) consent, then you will be financially responsible for payment for those items and Services.

Medical necessity

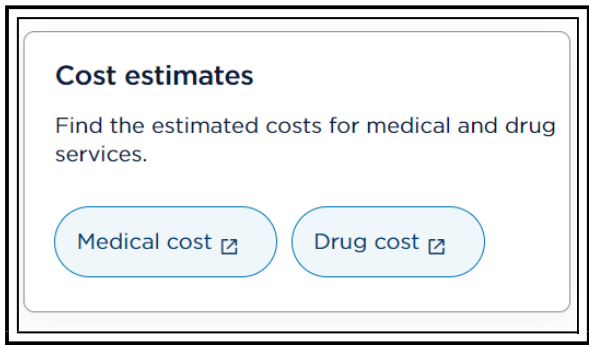
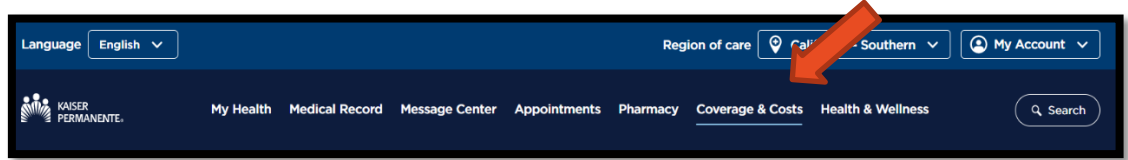
A Kaiser Permanente health professional will determine if Services are Medically Necessary for each member.

Cost Sharing (Copayments and Coinsurance)

The “Schedule of Benefits” describes the Cost Sharing you must pay for Covered Services. Cost Sharing is due at the time you receive the Services, unless Network Providers agree to bill you. 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). Copayments are applied per provider per day.

Unless specified otherwise, when Services can be provided in different settings, the Cost Sharing is applied per 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 Hospital Inpatient Services Cost Share is applied. If the same Service is performed in an office setting by a specialist, the specialty care office visit Cost Share is applied. If Services are provided in a hospital clinic setting, separate Cost Shares may apply to the hospital clinic charges and the physician charges; both hospital clinic and physician charges will be subject to applicable deductibles and Cost Share.

To estimate your Cost Sharing and plan your medical expenses sign into www.kp.org then select Coverage and costs.



Then select Medical or Drug Cost to get an estimate. From this page, you will be taken to an external estimation tool and logged out of www.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”.

The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

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.

- The Services included in Out-of-Pocket Maximum are identified in the “Schedule of Benefits.”

Note: If you are the only person on your plan, your plan will become a family plan **upon the addition of any eligible Dependent** to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days.

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
- Allergy Services
- Ambulance
- Bariatric Surgery - you must meet the certain criteria to be eligible for coverage
- Biofeedback
- Blood and blood products and their administration
- Chemotherapy
- Chiropractic care
- Dental Services for, Dental Radiation, Dental Anesthesia, Organ Transplantation
- Diagnostic x-rays and lab test and other diagnostic tests such as EEGs / EKGs performed during an office visit
- Dialysis Services
- Drugs that require administration or observation by medical personnel. Consultations with clinical pharmacists (at Kaiser Permanente Pharmacies Only)
- Durable Medical Equipment
- Habilitative and Rehabilitative Services
- Health Education
- Hearing Exam and Hearing Aids / Services – minor children
- 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
- Physical, Occupation & Speech Therapies
- Preventive care Services (see “Preventive Care Services” in this **“Benefits and Cost Sharing”** section for more details)
- Prosthetics and Orthotics
- Radiation therapy
- Respiratory therapy

- Surgical procedure performed in the office
- Ultraviolet light treatments

Note: See “Preventive Exams and Services” for information on covered preventive Services.

Hospital Inpatient Services

The following inpatient Services are covered:

- Acute inpatient rehabilitation (including physical, occupational, and speech therapy)
- Anesthesia
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs and endoscopic procedures
- Dialysis
- Dressings and medical supplies used or applied during an inpatient hospital admission
- Drugs that require administration or observation by medical personnel
- Network Physician Services (including consultation and treatment by specialists)
- General nursing care
- Medical social Services
- Medically necessary surgical or non-surgical treatment of TMJ (Dental treatment of TMJ dysfunction is not covered)
- Maternity care and delivery (including cesarean section and newborn care)
- Operating and recovery room (including FDA approved internally implanted Prosthetic devices such as pacemakers or artificial hips)
- Respiratory therapy
- Room and board (including a private room, if Medically Necessary)
- Specialized care and critical care units

Acupuncture Services

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.

To Locate a Network Provider Contact:

Colorado Region Visit www.kp.org or call 1-844-800-0788.

Allergy Services

Specialty or Primary Cost Share is based on the rendering provider. Services include allergy testing, serum and injections.

Ambulance Services

Emergency

Emergency Services provided by ground or air licensed ambulance is covered when you have an Emergency Medical Condition and are transported to an emergency facility. If provided through the 911 emergency response system, ambulance Services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital.

Scheduled

Non-emergency, scheduled ambulance trips are covered when a Network Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from Covered Services. Any applicable Cost Sharing is waived when you are transferred from a Non-Network Facility to a Network facility for care.

The following destinations are covered when Medically Necessary:

- Home to hospital and return
- Home to skilled nursing facility
- Hospital to skilled nursing facility
- Skilled nursing facility to hospital
- Skilled nursing facility to home
- Home to doctor's office
- Hospital to hospital
- Skilled nursing facility to dialysis center and return

Exclusion:

- Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered, even if it is the only way to travel to a facility.

Chiropractic Services

Chiropractic Services for the treatment of neuro musculoskeletal disorders are covered. Services include plain x-rays and adjunctive therapy associated with spinal, muscle or joint manipulation.

To Locate a Network Provider Contact:

Colorado Region – Visit www.kp.org or call 1-844-800-0788.

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 “Summary Chart” are covered outside an Approved Clinical Trial.

“Qualified Individual” means an enrollee who is eligible to participate in an Approved Clinical Trial per 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; or
- 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 through a system of peer review that the HHS Secretary determines meets all the following requirements:
 - i. It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
 - 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

Dental Related Medical Care**Dental Services for radiation treatment**

Dental evaluation, X-rays, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck are covered.

Dental Services pursuant to Transplants

Dental Services for potential transplant recipients who require pre-transplant dental evaluation and 'clearance' before being placed on the transplant wait list. Services include those necessary to ensure the oral cavity is clear of infection, such as evaluation, relevant x-rays, clearing, fluoride treatment, and extractions.

Dental anesthesia

For dental procedures, general anesthesia in a Network Hospital or ambulatory surgery center and the Services associated with the anesthesia are covered if any of the following are true:

- You are under age 7;
- You are developmentally disabled;
- You are not able to have dental care under local anesthesia due to a neurological or medically compromising condition; or
- You have sustained extensive facial or dental trauma.

Any other Service related to the dental procedure, such as the dentist's Services is not covered.

Exclusions:

- Accidental injury to teeth – the repair of sound natural teeth, related to an accidental injury.
- Dental coverage will not be provided for extractions, treatment of cavities, care of the gums or structures directly supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia (including braces), false teeth, or any other dental Services or supplies, except as listed above. Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.
- Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders). This exclusion does not include medical Services to correct TMJ disorders.

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 the Service Area;
- 2) You satisfy all medical criteria;
- 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. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Durable Medical Equipment (DME), External Prosthetics and Orthotics

DME must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered. A formulary is a list of DME, external prosthetics and orthotics covered by Kaiser Permanente. Examples of covered items include wheelchairs, hospital beds and oxygen. Medical supplies of an expendable nature, such as oxygen tubing, are covered if they are required for the effective use of the DME. Drugs purchased at the pharmacy for use in DME equipment are covered under the "Outpatient Prescription Drugs" benefit and not this benefit. To have coverage you must meet Kaiser Permanente's criteria for the use of any equipment and obtain items from a Network Provider. Coverage is limited to the standard equipment item that adequately meets your medical needs. Kaiser Permanente will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. Coverage includes fitting and adjustment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of loss, irreparable damage, wear or replacement required because of a change in your medical condition. You must return the equipment or pay the fair market price of the equipment when it is no longer covered.

The formulary guidelines allow you to obtain non-formulary DME (those not listed on the formulary for your condition) if they would otherwise be covered if KP criteria are met. To request a formulary exception contact Customer Service.

Internally implanted devices

Prosthetic and orthotic devices such as pacemakers, conventional intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, must be implanted during an approved surgery covered under another section of this "Benefits and Cost Sharing" section.

External Prosthetics

External Prosthetics must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered. Examples of external Prosthetic covered items include:

- Artificial arms and legs
- Ostomy and urological supplies
- Feeding tubes and enteral nutrition that is administered via a feeding tube
- One pair of eyeglasses or contact lenses, including fitting and dispensing fee, following cataract surgery.
- Contacts when the intraocular lens is absent and cannot be replaced such as in aphakia or when all or part of the iris is missing as in aniridia.

Orthotics

Orthotics must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered.

Services to determine the need for an external Prosthetic or an Orthotic and any subsequent fittings and adjustments are covered under the heading "[Outpatient Services](#)".

Exclusions:

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Comfort, convenience and luxury items and features
- Replacement of lost items
- Repair necessitated by misuse
- Exercise or hygiene equipment
- Shipping and handling, or restocking charges associated with obtaining DME, Prosthetics and Orthotics
- Spare or back up equipment
- Batteries or replacement batteries, except those specialized batteries used in covered DME equipment

Education and Training for Self-Management

Health education and training for self-management is covered when provided by a Network Physician or a qualified Network non-physician using a standardized curriculum to teach you how to self-manage your disease or condition. Education and training may be provided in group or individual sessions. Where available, sample conditions include:

- Asthma
- Diabetes
- Coronary artery disease
- Obesity
- Weight management
- Pain management

Emergency Services

Emergency Services include professional, facility and ancillary Services such as laboratory, x-ray or imaging Services necessary to diagnose and Stabilize your condition in an Emergency Department. See the "[Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers](#)" section for more information. Any applicable Cost Shares for emergency Services are waived when you are directly admitted to the hospital from the Emergency Department.

Fertility Services

Inpatient and outpatient fertility Services include any necessary procedures, laboratory and radiology Services and drugs administered by medical personnel.

Fertility Services include correcting underlying medical conditions causing infertility and artificial insemination. Additional eligible Services included advanced reproductive technologies such as in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT) and variations of these procedures (includes fertility preservation (Iatrogenic) Services of egg or ovarian tissue retrieval and short-term cryopreservation). Services to rule out the underlying

medical causes of Infertility and fertility preservation (Iatrogenic) Services of egg or ovarian tissue retrieval and short-term cryopreservation) are part of the medical benefit.

Fertility Preservation (Iatrogenic)

When planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long- term storage costs (anything longer than 12 months) are not covered.

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).

Exclusions:

- Donor semen or eggs, and Services related to their procurement and storage, including long term cryopreservation
- Cryopreservation and Storage greater than 1 year
- Services to reverse voluntary, surgically induced infertility (for example, because of a vasectomy or tubal ligation)
- Any experimental, investigational or unproven procedures or therapies
- Fertility Services when infertility is caused by or related to voluntary sterilization

Gender Affirming Surgery

When authorized by Kaiser Permanente, your Plan covers the cost of:

- Below waist surgery:
 - **Assigned at birth male** –clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasty, plastic repair of introitus, vaginoplasty
 - **Assigned at birth female** – hysterectomy, salpingo oophorectomy, colpectomy, phalloplasty, urethroplasty, scrotoplasty, plastic glans formation, Insertion of penile and testicular prosthesis
- Above waist surgery:
 - **Assigned at birth male** –Tracheal shave and facial hair removal, Medically Necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment is not sufficient for comfort in the social role and Medically Necessary gender confirming facial reconstruction
 - **Assigned at birth female** – Mastectomy with chest reconstruction and nipple/areola reconstruction or breast reduction
- Voice therapy lessons

Gender Affirming Surgery Limitations and Exclusions

- Above waist –
 - **Assigned at birth male** - lipoplasty of the waist, face lifts, blepharoplasty, collagen injections, or
 - **Assigned at birth female** - liposuction and cosmetic chest reconstruction, pectoral implants);

- Blepharoplasty
- Rhinoplasty
- Voice modification surgery
- Abdominoplasty
- Below waist Surgery –
 - **Assigned at birth female** - liposuction to reduce fat in hips thighs and buttocks, calf implants)
 - **Assigned at birth 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 used for cosmetic purposes);
- Cosmetic Surgery – Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered gender affirming surgery Services listed in this "Gender Affirming Surgery" section.
- Unless covered under the Fertility Benefit, 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.
- Referrals outside US.
- Other surgeries which have no Medically Necessary role in gender identification and are considered cosmetic in nature

Related Services Covered in this Covered Services Section

- Outpatient hospital or ambulatory surgery center Services
- Outpatient prescription drugs
- Outpatient administered drugs
- Prosthetics and orthotics
- Psychological counseling
- Outpatient imaging and laboratory

Hearing Aids - Pediatric

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

- Tests to determine the appropriate Hearing Aid model;
- Tests to determine the efficacy of the prescribed Hearing Aid;
- Visits for fitting, counseling, adjustment, cleaning and inspection after the warranty is exhausted; and
- Two Hearing Aids (each ear) every 60 months (unless alterations to existing hearing aid cannot adequately meet the needs of the child).

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. Hearing Aids on both ears 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 aged 18 and over.

Home Health Services

Skilled, part-time or intermittent home health Services are covered when you are confined to your home. Skilled home health Services are those Services provided by nurses, medical social workers, and physical, occupational and speech therapists. Medical supplies used during a covered home health visit are also covered. The Services are covered only if a Network Physician determines that you require skilled care, and it is feasible to maintain effective supervision and control of your care in your home. Home health aide Services are covered only when you are also getting covered home health care from one of the licensed providers mentioned previously.

Part-time or intermittent home health care visits are defined as follows:

- Up to two hours per visit for visits by a nurse and then each additional increment of two hours counts as a separate visit.
- Up to four hours per visit for visits by a home health aide is covered. Each additional increment of four hours counts as a separate visit.
- If billed a Home Health Agency, a visit by other providers such as a medical social worker, or physical, occupational, or speech therapist counts as 1 visit and counts toward the applicable visit limits regardless of the number of hours present.

The following types of Services and supplies are covered only as described under these headings in this [“Benefits and Cost Sharing”](#) section:

- Durable Medical Equipment (DME), External Prosthetics and Orthotics
- Home Infusion Services
- Outpatient Laboratory, X-ray, Imaging and Other Special Diagnostic Procedures
- Outpatient Prescription Drugs

Exclusions:

- Custodial Care - (For example: care an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training). This care is excluded even if the care would be covered if it were provided by a qualified medical professional in a hospital or a skilled nursing facility.
- Full time nursing care in the home
- Homemaker services and supplies, including meals delivered to your home
- Home health care a Network Physician determines may be more appropriately provided for you in a Network Facility, Network Hospital or a Network Skilled Nursing Facility

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

If a Network Physician diagnoses you with a terminal illness and determines that your life expectancy is twelve (12) months or less, you may choose home-based hospice care instead of traditional Services that you would otherwise receive for your illness. If you choose hospice care, you are choosing to receive care to reduce or relieve pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may continue to receive Covered Services for conditions other than the terminal illness. You may change your decision to receive hospice care at any time.

The following Services and supplies are covered on a 24-hour basis:

- Network Physician and nursing care
- Counseling and bereavement Services
- Physical, occupational, speech or respiratory therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Medical social Services
- Home health aide and homemaker Services
- Covered Durable Medical Equipment and Medical supplies
- Palliative care prescription drugs, in accordance with Kaiser Permanente's drug formulary guidelines
- Short-term (no more than 5 days at a time) inpatient care, limited to respite care and care for pain control, and acute and chronic symptom management
- Dietary counseling

Maternity Services

See the "Preventive Services" section for information on Prenatal Services covered at zero cost share.

The Plan covers physician charges for maternity care, delivery and postnatal care. Also covered are hospital Services (including network birthing centers) and newborn care.

Notes:

- 1) If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.
- 2) Circumcision is covered for eligible newborns during the first 31 days of life regardless of Medical Necessity and thereafter only when Medically Necessary.
- 3) **Newborn child.** A Participant's or a Participant Spouse's 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 eligible for benefits past the first 31 days of life, unless enrolled as a dependent.
- 4) During the first 31-day period after birth, benefits for an eligible newborn child shall consist of Medically Necessary care for injury and sickness, including well childcare and treatment of medically diagnosed Congenital Defects and Birth Abnormalities. **Services provided during the first 31 days of coverage may be subject to the Cost Sharing requirements and any benefit maximums applicable to other sicknesses, diseases and conditions otherwise covered.** **Note:** If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days.
- 5) To continue the newborn's participation in the Plan beyond the 31-day period after the newborn child's birth, contact your Employer. Your 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 15th you have 31 days from the birth to notify the Employer of the newborn's birth.

Medical Foods

Special oral foods are foods that are prescribed by a Network Provider and used in the treatment of certain medical conditions, such as phenylketonuria (PKU) and other inherited diseases of amino acids and organic acids caused by genetic defects that can lead to life threatening abnormalities in body chemistry. Special oral foods are not foods that are generally available in retail grocery stores. Special oral foods are not used with feeding tubes. For coverage of nutritional formulas delivered via a feeding tube see the Durable Medical Equipment, External Prosthetics and Orthotics heading in this "[Benefits and Cost Sharing](#)" section.

Mental Health Services

Evaluation, crisis intervention, and treatment are covered for mental health conditions.

Inpatient

Inpatient psychiatric care (including residential treatment centers) is covered in a Network Hospital or licensed residential treatment facility. Coverage includes room and board, drugs, Services of Network Physicians, and Services of other Network Providers who are mental health professionals.

Outpatient Therapy

The following outpatient mental health care is covered:

- Partial Hospitalization, sometimes known as day-night treatment programs

- Intensive outpatient programs
- Individual and group visits for diagnostic evaluation and psychiatric treatment
- Other Services:
- Psychological testing
- Biofeedback and electroconvulsive therapy (ECT)
- Visits for monitoring drug therapy

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.

Outpatient Laboratory, X-ray, Imaging and Other Special Diagnostic Procedures

Outpatient laboratory, radiology, and diagnostic Services are covered when provided in an urgent care, free standing laboratory, radiology or imaging center, or Hospital outpatient department for the diagnosis of an illness or injury. Such Services include

- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available
- X-rays and diagnostic imaging, including Magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET) and nuclear medicine exams
- Special procedures such as electrocardiograms and electroencephalograms are included in your office visit cost share

Outpatient laboratory, radiology, and diagnostic Services performed during an office visit are considered part of the office visit.

Note: See “Preventive Exams and Services” for information on covered preventive laboratory, x-ray, imaging and diagnostic procedures.

Outpatient Prescription Drugs

Outpatient drugs, supplies, and supplements are covered when ALL requirements below (1-5) are met:

1. The item is prescribed by a Network Provider authorized to prescribe drugs or by one of the following Non-Network Providers:
 - A dentist;
 - A Non-Network Provider to whom you have been referred by a Network Physician;

- A Non-Network Provider (if you got the prescription in conjunction with covered Out-of-Area Urgent Care or Emergency Services);
 - A Community Pharmacy (in a Service Area outside of California; or
 - A first refill of prescription originally filled prior to enrollment in the Plan).
2. The item is prescribed in accordance with Kaiser Permanente drug formulary guidelines.
 3. Items provided to eligible newborns during the first 31 days of life and or prior to enrollment of a newborn, require prepayment and claims submission for reimbursement.
 4. You get the item from a Network Pharmacy or the Kaiser Permanente mail order Service, except that you can get the item from a Non-Network Pharmacy if you obtain the prescription in conjunction with covered Urgent Care or Emergency Service outside the Service Area and it is not possible for you to get the item from a Network Pharmacy. Please refer to www.kp.org for the locations of Network Pharmacies in your area.
 5. The item is one of the following:
 - Drugs that require a prescription by law including.
 - Contraceptive drugs (including the emergency contraceptive pill and devices, such as diaphragms and cervical caps and over the counter contraceptives when prescribed by a Network physician);
 - Growth hormone; or
 - Smoking Cessation products.
 - Drugs that don't require a prescription but are listed on Kaiser Permanente's drug formulary.
 - Diabetic supplies such as insulin, syringes, pen delivery devices, blood glucose monitors, test strips and tablets. Other diabetic supplies may be covered under Durable Medical Equipment.
 - Specialty drugs – high-cost drugs contained on the KP specialty drug list. To obtain a list of specialty drugs on the KP formulary, or to find out if a non-formulary drug is on the specialty drug list, please call Customer Service.

Kaiser Permanente uses a “formulary”. A “formulary” is a list of drugs that have been approved for coverage by the Pharmacy and Therapeutics Committee. The drug formulary guidelines allow you to obtain non-formulary prescription drugs (those not listed on the drug formulary for your condition) if they would otherwise be covered if the criteria for an exception are met. To request a formulary exception, contact Customer Service. Prescriptions written by dentists are not eligible for non-formulary exceptions.

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the formulary includes a pre-determined amount of an item that constitutes a Medically Necessary day's supply. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (the Pharmacy can tell you if a drug you take is one of these drugs). **Note:** episodic drugs prescribed for the treatment of sexual dysfunction disorders may be limited by number of doses within a 30-day period.

If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug

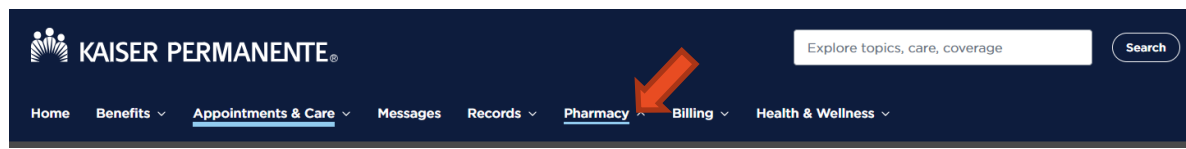
was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

Mail order service, subject to any Limitations and Copayments, is available. Not all drugs are available through the mail order service. Examples of drugs that cannot be mailed include:

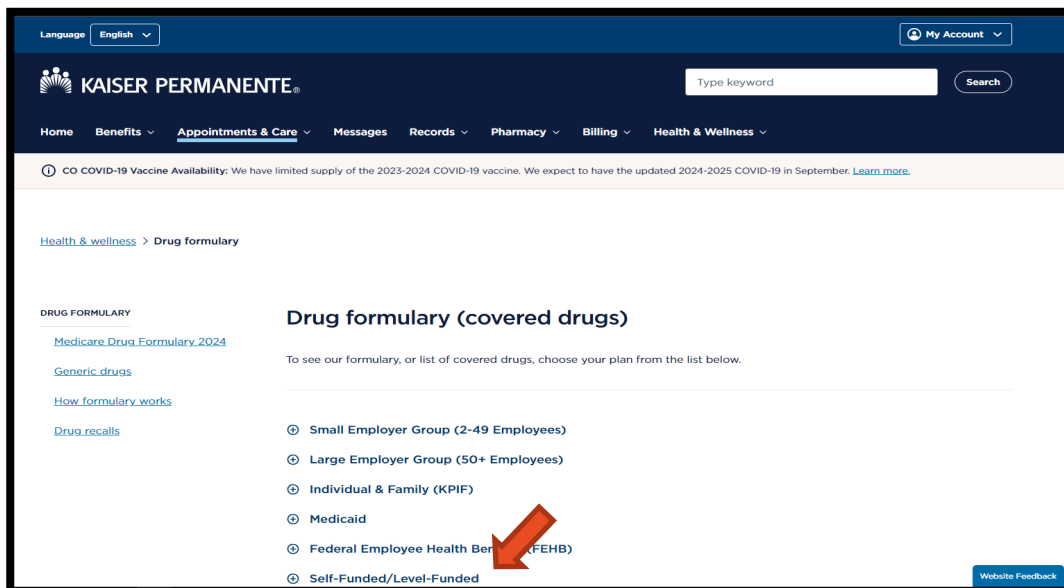
- Controlled substances as determined by state and/or federal regulations;
- Medications that require special handling; and
- Medications affected by temperature.

Refills may be ordered from Kaiser Pharmacies, the mail-order program, or on-line at www.kp.org. A Kaiser Pharmacy can provide more information about obtaining refills.

To locate a Network Pharmacy, learn more about mail order, or print a claim form, sign on to www.kp.org and click on “Pharmacy” or you may also call OptumRx at 1-866-427-7701.



To view the applicable formulary, search for the word “Formulary” on the www.kp.org website, then click on “Formulary (covered drugs),” and then click on “Self-Funded Formulary.” You can then choose an English language or Spanish language version of the formulary.



For outpatient prescription drugs and/or items covered under this Outpatient- Prescription Drug section and obtained at a pharmacy owned and operated by Kaiser Permanente, you may use certain manufacturer coupons you have procured, when allowed by law (i.e., on HSA plans you must satisfy your deductible prior using a coupon) and approved by Kaiser

Permanente, as payment of Your Cost Sharing. You will owe any additional amount if the coupon does not cover the entire amount of Your Cost Sharing for Your prescription. If the coupon is for an amount greater than the Cost Sharing amount you owe for your prescription, no credit, cash or other refund will be given for the excess amount. When a coupon is accepted toward satisfaction of Your Cost Sharing, an amount equal to the coupon value and, if applicable, any additional amount that you pay, will accumulate to Out-of-Pocket Maximum. Kaiser Permanente reserves the right to change the terms and conditions of its coupon program, including but not limited to the types and amounts of coupons that will be accepted at any time without prior notice. You may obtain information regarding the Kaiser Permanente coupon program at www.kp.org and search on the term “coupons”. Acceptance of your coupon does not relieve you of your responsibility regarding Cost Sharing if the drug manufacturer does not honor the coupon in whole or in part or if Kaiser Permanente later determines that the coupon was not allowed. www.kp.org/rxcoupons.

Exclusions:

- If a Service is not covered under this Plan, any drugs or supplies needed relating to that Service are not covered
- Compounded products unless the drug is listed on the drug formulary or one of the ingredients requires a prescription by law
- Drugs used to enhance athletic performance
- Drugs used in the treatment of weight control
- Experimental or Investigational Drugs
- Drugs prescribed for cosmetic purposes
- Replacement of lost, damaged or stolen drugs
- Drugs that shorten the duration of the common cold
- Special packaging (Packaging of prescription medications is limited to Kaiser Permanente standard packaging)
- Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product (Exception: those items listed in the Schedule of Benefits and the Preventive Exams and Services section below)
- Drugs or devices for which there is an over-the-counter equivalent
- Drugs used in the fertility treatment
- Drugs used in the treatment of Sexual Dysfunction

Preventive Exams and Services

Preventive care refers to measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

1. protects against disease such as in the use of immunizations;
2. promotes health, such as counseling on healthy lifestyles; and
3. detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

Preventive Services listed on www.kp.org search on the term “preventive care” are covered as required by the Patient Protection Affordable Care Act (PPACA) and are not subject to Deductibles, Copayments or Coinsurance. Consult with your physician to determine what preventive Services are appropriate for you. Please note, state-specific preventive mandates, recommendations in effect for less than one year may not be applicable to your

Plan. Preventive Services will be applied based on the member's medical status regardless of stated gender.

Preventive Services may change according to federal guidelines, and your benefits will be updated to include these changes as they are made throughout the Plan year. You will be notified at least sixty (60) days in advance, if any item or Service is removed from the list of covered Services.

For a complete list of current United States Preventive Service Task Force (USPSTF) A&B recommended preventive Services required under the Patient Protection Affordable Care Act for which cost share does not apply, please call: the customer Service number on the back of your ID card or visit: <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

Exclusions for Preventive Care

- Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases
- Upgrades of breast-feeding equipment, unless determined to be Medically Necessary and prescribed by your physician.

Note: The following Services are not included under the Preventive Exams and Services benefit but may be Covered Services elsewhere in this Benefits Booklet:

- Lab, Imaging and other ancillary Services associated with prenatal care not inclusive to routine prenatal care
- Non-routine prenatal care visits
- Non-preventive Services performed in conjunction with a sterilization
- Lab, Imaging and other ancillary Services associated with sterilizations
- Treatment for complications that arise after a sterilization procedure

Reconstructive Surgery

Coverage is provided for inpatient and outpatient reconstructive Services that:

- Will result in significant improvement in physical function for conditions because of injuries illness, congenital defects or Medically Necessary surgery.
- Will correct significant disfigurement resulting from an injury, illness or congenital defects or Medically Necessary surgery.

Following Medically Necessary removal of all or part of a breast, reconstruction of the breast as well as surgery and reconstruction of the other breast to produce a symmetrical appearance is covered.

Correction of congenital hemangioma (known as port wine stain) is limited to hemangiomas of the face and neck for children aged 18 years and younger.

Exclusions:

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

Rehabilitative and Habilitative Services (Including Early Intervention Services for Developmental Delays

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery

from injury, illness, or disease to as normal a condition as possible. Habilitative Services are therapeutic Services that are provided to children with congenital conditions (present from birth), and developmental delays to enhance the child's ability to function and advance. Habilitative Services are like rehabilitative Services that are provided to adults or children who acquire a condition later in life. Rehabilitative Services are geared toward reacquiring a skill that has been lost or impaired, while habilitative Services are provided to help acquire a skill in the first place, such as walking or talking. Habilitative Services include, but are not limited to, physical therapy, occupational therapy and speech therapy for the treatment of a child with a congenital or genetic birth defect or developmental delays.

The following rehabilitative and Habilitative Services are covered as described in the "Benefits and Cost Sharing" section:

- Inpatient and Outpatient Multidisciplinary Rehabilitation in an approved organized multidisciplinary program or facility;
- Outpatient Physical, Occupational, and Speech Therapy (not billed by a Home Health Agency);
- Outpatient Cardiac Rehabilitation; or
- Outpatient Pulmonary Rehabilitation.

Exclusions:

- Maintenance therapy; or treatment when the Participant has no restorative potential;
- Treatment for congenital learning or neurological disability/disorder;
- Treatment is for communication training, educational training or vocational training;
- Therapy primarily indicated for vocational training or re-training purposes, including sports physical therapy;
- Speech therapy that is not Medically Necessary, such as:
- Therapy for educational placement or other educational purposes;
- Training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or
- Therapy for tongue thrust in the absence of swallowing problems.
- Physical therapy Services administered under the home health or hospice benefit, or in a hospital or skilled nursing facility. Passive modalities and/or treatment Services associated with physical therapy (e.g. electrical stimulation)

Therapies for Congenital Defects and Birth Abnormalities

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

Note 1: This benefit is also available for eligible children under the age of three (3) who are

not participating in Early Intervention Services.

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

Early Intervention Services Provided Through Community Centered Board (CCB)

A. Definition

1. In 2007, Colorado Senate Bill 004 was passed which mandates insurers to provide coverage for Early Intervention Services (EIS) for qualifying children up to an annually adjusted maximum.
2. Examples of EIS are: occupational, speech and physical therapy which are documented in an Individualized Family Service Plan (IFSP) and developed by a Community Centered Board (CCB) or another entity designated by the State as an EIS broker.
3. In addition, EIS may incorporate other Services such as social Services, educational Services and nutritional Services as determined by the CCB.
4. Coverage is for children from birth up to their third birthday, 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.

B. Coverage

1. EIS is not subject to any Copayments, Coinsurance, Deductibles or Out-of- Pocket Maximums.
2. Members are liable for any EIS received after the maximum amount permitted by State law is satisfied.
3. If a member's need for therapy meets the language in their contract (subject to significant improvement through relatively short-term therapy) then the member is entitled to their contractual benefit in addition to any EIS or state mandated Services

C. Operational Process

1. Parents must contact a CCB. An IFSP will be developed by a team of people including health care providers and parents that will document a child's eligibility for the Services he or she needs.
2. The CCB must provide the IFSP to the Kaiser Permanente IFSP Coordinator so payment can be issued to the State.
3. To locate a CCB, parents can call the Colorado Department of Human Services at 303-866-5700 or access their web site.

D. Limitations

The maximum amount of coverage permitted by State law does not apply to:

1. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical condition; or
2. 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 Act"; or
3. Services that are not provided in an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended (although standard benefit limitations do apply).

E. Exclusions

EIS does not cover the following:

1. Non-emergency transport

2. Respite care
3. Service coordination (as defined by State and Federal law)
4. Assistive technology (except for durable medical equipment otherwise covered under this plan)

The Following Additional Habilitative Services are Covered

Treatment for Pervasive Developmental Disorders

Covered Services for pervasive developmental disorder or autism include:

- Medically Necessary Inpatient, Skilled Nursing Home and Outpatient care;
- Behavioral health treatment;
- Applied behavior analysis and evidence-based behavior intervention programs that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism.

Covered Services for pervasive developmental disorder or autism must meet all the following criteria:

- The treatment is referred by KPIC and administered by a Network Provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Network Qualified Autism Service Provider.
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate and the treatment plan includes:
 - the behavioral health impairments to be treated;
 - an intervention plan that includes the Service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the progress is evaluated and reported;
 - utilizes evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; and
 - discontinues intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for either of the following:
 - for purposes of providing (or for the reimbursement of) respite care, day care, or educational Services; or
 - to reimburse a parent for participating in the treatment program.

Note that certain Services require Prior-Authorization:

- All inpatient and outpatient facility Services (excluding emergencies);
- Office based habilitative / rehabilitative care: ABA, Occupational; Speech, and Physical therapies;
- All Services provided outside a KP facility;
- All Services provided by Non-Network Providers; and
- Drugs and Durable Medical Equipment not contained on the KP formulary.

Exclusions:

- Services not identified in an approved treatment plan;
- Teaching manners and etiquette;
- Teaching and support Services to develop planning skills such as daily activity

- planning and project or task planning;
- Items and Services for the purpose of increasing academic knowledge or skills;
- Teaching and support Services to increase intelligence;
- Academic coaching or tutoring for skills such as grammar, math, and time management;
- Teaching you how to read, if you have dyslexia;
- Educational testing;
- Teaching skills for employment or vocational purposes;
- Professional growth courses; and
- Training for a specific job or employment counseling.

Skilled Nursing Facility Services

Skilled inpatient Services and supplies must be Services customarily provided by a Skilled Nursing Facility and must be above the level of Custodial Care or intermediate care. The following Services and supplies are covered:

- Network Physician and nursing Services.
- Room and board.
- Medical social Services.
- Prescribed drugs.
- Respiratory therapy.
- Physical, occupational, and speech therapy.
- Medical equipment ordinarily furnished by the Skilled Nursing Facility.
- Medical supplies.
- Imaging and laboratory Services ordinarily provided by SNFs.
- Blood, blood products and their administration.

Exclusion:

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

Substance Use Disorder Services

Inpatient

Hospitalization (including Residential Treatment) is covered for medical management of withdrawal symptoms, including room and board, Network Physician Services, drugs that require administration or observation by medical personnel, dependency recovery Services, and counseling. Substance Use Disorder Rehabilitation Services in a licensed residential treatment Network Facility are also covered.

Outpatient

The following Services for treatment of Substance Use Disorders are covered:

- Partial hospitalization, sometimes known as day-night treatment programs;
- Intensive outpatient programs;
- Individual and group counseling visits; and
- Visits for medical treatment for withdrawal symptoms.

Transplant Services

Inpatient and outpatient Services for transplants of organs or tissues are covered –

for example:

- Bone Marrow transplant/stem cell rescue
- Cornea
- Heart
- Heart & lung
- Liver
- Lung
- Kidney; Simultaneous kidney & pancreas
- Pancreas; Pancreas after kidney alone
- Small bowel; Small bowel & liver

The Services are covered if:

- KPIC has determined that you meet certain medical criteria for patients needing transplants; and
- KPIC provides a written referral to an approved transplant facility. The facility may be located outside the Service Area. Transplants are covered only at a facility approved by KPIC, even if another facility within the Service Area could perform the transplant.

Covered Services include:

- Reasonable transportation and lodging expenses outside of the Service Area when approved in advance by Kaiser Permanente. Coverage will include the transplant recipient plus, one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant are covered only if such expenses are incurred for Services within the United States or Canada. Coverage of expenses for these Services is subject to Living Donor Guidelines on www.kp.org.

Exclusions:

- Kaiser Permanente does not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Organ/tissue transplants which are experimental or investigational are not covered.

Urgent Care Services

Urgent Care Services are sometimes referred to as after-hours care.

In the Service Area

Urgent Care Services are covered and may be provided in your doctor's office after office hours or a Network urgent care facility. If you think you may need urgent care, call the advice nurse telephone number for help(See the "CUSTOMER SERVICE PHONE NUMBERS" section or www.kp.org). **Note:** Urgent Care received in a Kaiser Permanente Service Area from a Non-Network provider or emergency department is not covered.

Exclusions:

- Except as noted below, Urgent Care Services from Non-Network Providers are not covered.

Outside of the Service Area

Urgent Care Services are also covered when you are temporarily away from the Service Area. Urgent Care Services are covered when they are Medically Necessary, and it is not reasonable given the circumstances to obtain the Service through Network Providers. See the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers” section for more information. Note you may be required to pay the bill in full and submit a claim for reimbursement.

Vision Exams (routine)

Routine eye exams (eye refractions) provided by Network optometrists or ophthalmologists to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses are covered.

Exclusions:

- Corrective lenses, eyeglasses, frames, and contact lenses (including the fitting of contact lenses) except as notated in vision hardware, are not covered except that this exclusion does not apply to Services covered under “Durable Medical Equipment (DME), External Prosthetics and Orthotics” in the “Benefits and Cost Sharing” section
- All Services related to eye surgery for correcting refractive defects such as nearsightedness, farsightedness or astigmatism (for example, radial keratotomy and photo-refractive keratectomy)
- Orthoptic therapy, a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision
- Visual training
- Low vision aids and Services

GENERAL EXCLUSIONS, GENERAL LIMITATIONS, COORDINATION OF BENEFITS AND REDUCTIONS

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.

Before coverage begins - Any Services, drugs, or supplies you receive while you are not enrolled in this Plan
Behavioral/conduct problems - Therapies and Services delivered in a non-clinical setting such as educational therapies and programs for behavioral/conduct problems.
Blood - The cost of whole red blood or red blood cells when they are donated or replaced and billed, except expenses for administration and processing of blood and blood products (except blood factors) covered as part of inpatient and outpatient Services.
Care by non-Network Providers except for Authorized referrals, emergencies and out of area Urgent Care
Care in a halfway house
Cosmetic Services - Except for Medically Necessary reconstructive surgery and related Services.
Custodial Care. Assistance with activities of daily living (for example: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine), 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. This exclusion does not apply to Services covered under "Hospice Care"
Dental Services. Not listed elsewhere in your coverage. This exclusion also applies to accidental injury to sound and natural teeth.
Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
Education - Services other than Health Education or self-management of a medical condition as determined by the Plan to be primarily educational in nature.
Excluded Providers: Services, supplies, equipment or prescriptions provided by OIG (Office of the Inspector General) excluded providers.

Experimental or investigational Services

Kaiser Permanente, determines that a Service is experimental and investigational when:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients);
 - It requires government approval that has not been obtained when Service is to be provided;
 - It cannot be legally performed or marketed in the United States without FDA approval;
 - It is the subject of a current new drug or device application on file with the FDA;
 - It has not been approved or granted by the U.S. Food and Drug Administration (FDA) excluding off-label use of FDA approved drugs and devices
 - It 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;
 - It is subject to approval or review of an Institutional Review Board or other body that approves or reviews research;
 - It is provided pursuant to informed consent documents that describe the Services as experimental or investigational, or indicate that the Services are being evaluated for their safety, toxicity or efficacy; or
 - The prevailing opinion among experts is that use of the Services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the Service;
 - It is provided for Non-referred Services in connection to an approved clinical trial and/or Services in connection with a non-approved clinical trial;
- Services related to Clinical Trials are considered Experimental and Investigational when;
- Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
 - Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
 - Items or Services needed for reasonable and necessary care arising from the provision of an investigational item or Service--in particular, for the diagnosis or treatment of complications.

Fertility Services: The following and related services:

- Reversal of male and female voluntary sterilization
 - Fertility Services when the infertility is caused by or related to voluntary sterilization
 - Any experimental, investigational or unproven fertility procedures or therapies.
- This exclusion does not apply to services to rule out the underlying medical causes of infertility.

Foot care except when Medically Necessary

Gender Affirming related Services listed below:

Cosmetic Surgery

Sperm procurement and storage in anticipation of future infertility, unless covered under Fertility Services benefit

Gamete preservation and storage in anticipation of future infertility, unless covered under Fertility Services benefit

Cryopreservation of fertilized embryos in anticipation of future infertility, unless covered under Fertility Services benefit

Other electrolysis or laser hair removal not specified as covered

Drugs used for cosmetic purposes (reduction of unwanted hair) are excluded

<p>Government Obligations - Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy for which the federal government has primary responsibility for payment. Also excluded are charges for Services directly related to military Service provided or available from the Veterans' Administration or military medical facilities as required by law</p>
<p>Government programs - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.</p>
<p>Hypnotherapy (Hypnosis)</p>
<p>Illegal Services Treatments, procedures, equipment, drugs, devices, supplies or any other plan benefits, in each case, that are illegal under applicable law.</p>
<p>Licensed Provider Charges for a Provider acting outside the scope of his license.</p>
<p>Massage Therapy except when provided as part of other covered Services</p>
<p>Medical supplies - Disposable supplies for home use, excluding urological and ostomy supplies</p>
<p>Medicare Benefits. Your benefits are reduced by any benefits to which You are entitled under Medicare except for Members whose Medicare benefits are secondary by law.</p>
<p>Network or Non-Network Provider (Close Relative) – Services rendered by a Network or Non-Network Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother, or sister, by blood, marriage or adoption.</p>
<p>Nutritional supplements and formulas except for formula needed for the treatment of inborn errors of metabolism</p>
<p>Obesity - Fees or costs associated with weight reduction programs, fees and charges relating to fitness programs, weight loss or weight control programs, except for Network Diabetes prevention programs.</p>
<p>Outpatient Prescription Drugs Drugs prescribed for cosmetic purposes Drugs that shorten the duration of the common cold Drugs used to enhance athletic performance As determined by Kaiser, Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product except where noted in your Schedule of Benefits Experimental or Investigational Drugs If a Service is not covered under this Plan, any drugs or supplies needed in connection with that Service are not covered As determined by Kaiser, Prescription drugs for which there is an over-the-counter drug equivalent except where noted in your Schedule of Benefits Replacement of lost, damaged or stolen drugs Special packaging; packaging of prescription medications is limited to Kaiser Permanente standard packaging Drugs used in the treatment of Sexual Dysfunction Drugs used in the treatment of Weight Control</p>
<p>Personal Comfort Items for Home use: Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for you or your Dependent, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench, air conditioners, air purifiers and filters, batteries and charges, dehumidifiers, humidifiers, air cleaners and dust collection devices.</p>

Personal comfort items when Inpatient -Services and supplies not directly related to medical care, such as guest's meals and accommodations, hospital admission kit, barber Services, telephone charges, radio and television rentals, homemaker Services, over the counter convenience items and take-home supplies.
Private Duty Nursing as a registered bed patient
Private Duty Nursing in home or long-term facility
Private room unless Medically Necessary or if a semi-private room is not available
Recreational, diversional and play activities
Religious, personal growth counseling or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling unless the primary patient has a mental health diagnosis.
Services, drugs, or supplies if not Medically Necessary
Services billed more than 365 days after the date of Service or dispensing.
Services for conditions that a Network Physician determines are not responsive to therapeutic treatment.
Services provided outside the United States- Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States
Services related to a non-Covered Service- All Services, drugs, or supplies related to the non-Covered Service are excluded from coverage, except Services we would otherwise cover for the treatment of complications and rehabilitation of the non-Covered Service
Services that Are the Subject of a non-Network Provider's Notice and Consent Amounts owed to non-Network Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable federal law.
Shoes - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
Surrogacy - Services related to conception, pregnancy or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
Testing for ability, aptitude, intelligence or interest
Third Generation Dependents. Services related to third generation dependents, unless enrolled covered as a dependent, (includes temporary enrollment under the plan for a limited number of days after birth).
Third Party Requests: Services, reports and/or examinations in connection with employment, participation in employee programs, insurance, disability, licensing, immigration applications, or on court order or for parole or probation.
Travel or transportation expenses even though prescribed by a Network Physician or non-Network Physician except as noted as covered in the Summary of Benefits.
Vision (Surgical Correction) - Radial keratotomy; and surgery, Services, evaluations or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem
Vision - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
Vision - Low vision aids, eyeglasses, and contact lenses for prescription or fitting and follow-up care thereof. <u>Exception:</u> The purchase of eyeglasses, lenses, frames, or contact lenses that follows cataract surgery (first pair only) or loss of lens due to eye disease for aphakia or aniridia.

Vision - Hardware (eyeglasses, lenses, contact lenses) as prescribed to correct visual acuity
Waived fees - Free Services (no charge items)
Wigs and toupees
Workers' Compensation - Services for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if covered by the Plan. Services or supplies for injuries or diseases related to you or your Dependent's job to the extent you or your Dependent is required to be covered by a workers' compensation law.

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 based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount more than 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 based on negotiated fees, an amount more than 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 based on usual and customary fees and another Coverage Plan that provides its benefits or Services based on 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 per 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 about 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, because 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:
 - (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:
 - (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 thus, 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 thus, 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 is the Secondary Coverage Plan.
 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 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.

To determine when Medicare is primary see the excerpt from <https://www.medicare.gov/publications/10050-Medicare-and-You.pdf> below:

How does my other insurance work with Medicare?

When you have other insurance (like group health plan, retiree health, or [Medicaid](#) coverage) and Medicare, there are rules for whether Medicare or your other coverage pays first.

If you have retiree health coverage (like insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees ...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees ...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees ...	Medicare pays first.
If you have group health plan coverage based on your or a family member's employment or former employment, and you're eligible for Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan pays first for the first 30 months after you become eligible for Medicare. Medicare pays first after this 30-month period.
If you have TRICARE...	Medicare pays first, unless you're on active duty, or get items or services from a military hospital or clinic, or other federal health care provider.
If you have Medicaid...	Medicare pays first.

Important!

If you're still working and have employer coverage through work, contact your employer to find out how your employer's coverage works with Medicare.

Here are some important facts to remember about how other insurance works with Medicare-covered services:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary payer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your group health plan or retiree health coverage is the secondary payer, you might need to sign up for Part B before your insurance will pay.

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can also call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Important! If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare's Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627.

If you have Part A, you may get a "Health Coverage" form (IRS Form 1095-B) from Medicare. This form verifies that you had health coverage in the past year. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry. You don't need it to file your taxes.

- For more information on Medicare and ESRD see <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD>
- 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 to administer this "Coordination of Benefits" section. This shall include getting the facts needed from, or giving them to, other organizations or persons for 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. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Trust has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means the Trust 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 any 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 right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- 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 with KPIC as provided above 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 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, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium 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 benefits advanced.
- If you receive any payment from any party because of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Trust, you and /or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy – including no-fault benefits, PIP benefits and/or medical payment benefits – other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- 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 you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's 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 death, giving rise to any 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. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- 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 any 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 any 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.
- If you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the subscriber, 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 your failure to abide by the terms of the Plan. If we incur attorneys' fees and costs to collect third party settlement funds held by you or your representative, we have 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 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:

Kaiser Permanente Insurance Company
99 So. Oakland Avenue
Pasadena, CA 91101

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 relating to 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 a Surrogacy Arrangement, you must send written notice of the arrangement to the address listed below, including all 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

Kaiser Permanente Insurance Company
99 So. Oakland Avenue
Pasadena, CA 91101

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:

- at a Kaiser Permanente Facility (please refer to www.kp.org for addresses)
- by calling Customer Service 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 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. There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

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, KPIC 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, KPIC 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.

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 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 for a specific period or number of treatments.

Type of Notice or Claim Event	Urgent Care Claim	Pre-Service Care Claim	Post-Service Care Claim
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.
Notice of Initial Claim Decision	<p>If the claim when initially filed is proper and complete, a decision will be made as soon as possible, considering the medical exigencies, but not later than 72 hours after receiving the initial claim.</p> <p>If the claim is not complete, the KPIC 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.</p>	<p>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 KPIC. You shall be notified within the initial 15 days if an extension will be needed. The notice shall state the reason for the extension.</p> <p>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-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, whichever is earlier.</p>	<p>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 KPIC. You shall be notified within the initial 30 days if an extension will be needed. The notice shall state the reason for the extension.</p> <p>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 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.</p>

*All listed time frames are calendar days

Concurrent Care Claims

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, KPIC 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 KPIC 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 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 KPIC 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.

Post Service Claims

To obtain payment from the Plan when 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.

If you miss a deadline for filing a claim or appeal, review may be declined. Before you can file a civil action under ERISA section 502(a)(1)(B), you must meet any deadlines and exhaust the claims and appeals procedures set forth in this “CLAIMS AND APPEALS” section. There is no charge to 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 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 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; log in, and go to *Billing, then Claims & costsselect Submit a 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 chooses to do so.

If a Claim Is Denied

If all or part of your claim is denied, KPIC 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) 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.

Note: You have the right to request any diagnostic and treatment codes and their meanings that may be the subject of your claim. To make such a request, contact Customer Service at the number on your identification card.

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 your written appeal to the address that corresponds to the region in which you receive your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-888-225-7202
Northwest	Washington
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 Phone: 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone: 1-866-458-5479 Fax: 1-206-630-1859

Or for Urgent appeals submitted over the phone call:

Oral Appeal
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. You may be required 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 <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting>.

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.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgement letter, sent to you within five days after we receive your appeal. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgement letter. We will add the information that you provide through testimony or other means to your appeal file, and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services.

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.

KPIC will review the claim, considering 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 about the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Timing of Initial Appeal Determinations

KPIC 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 72 hours after receiving the appeal.	Not later than 15 days after receiving the appeal	Not later than 30 days after receiving the appeal.

*All listed time frames are calendar days

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, KPIC 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 180 days after the date of notice that your initial appeal is denied.

Send your written appeal to the address that corresponds to the region in which you receive your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-888-225-7202
Northwest	Washington
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone 1-866-458-5479 Fax 1-844-660-1859

Or for Urgent appeals submitted over the phone call:

Oral Appeal
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card

Timing of Final Appeal Determinations

For Pre-Service Claims and Post-Service Claims, KPIC 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.

*All listed time frames are calendar days

Notice of Determination on Final Appeal

Within the time prescribed in the “Timing of Final Appeal Determinations” section, KPIC will provide you with written notice of its decision. If KPIC determines that benefits should have been paid, KPIC 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.

Next Steps

If after exhausting the appeals process, you are still not satisfied, your remaining remedies include the right to sue in Federal Court under Section 502(a) of ERISA and voluntary dispute resolution options, such as mediation or independent External Review as described below.

You must commence any legal or equitable action for benefits within two years after the date that notification is sent to the participant or beneficiary (and/or his or her authorized representative) that the adverse benefit determination has been upheld on appeal.

External Review

If you are still dissatisfied you may have a right to request an external review by an independent third-party when our final appeal determination (1) relies on medical judgment (including but not limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit), (2) concludes that a treatment is experimental or investigation; (3) concludes that parity exists in the non- quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits; (4) involves consideration of whether We are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130); or, (5) involves a decision related to rescission of your coverage.

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 Denial, please submit your request in writing with the following information to the address that corresponds to the region in which you receive your care:

- Name
- Phone Number
- Medical Record Number
- Statement indicating you are requesting an “External Review”
- What you are appealing
- Any supporting documentation (e.g. appeal denial letter)

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-888-225-7202
Northwest	Washington
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone 1-866-458-5479 Fax 1-844-660-1859

Or for Urgent appeals submitted over the phone call:

Oral Appeal
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card

Preliminary Review of External Review Request

Within five business days following the date of receipt of the external review request, KPIC 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, KPIC 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 KPIC 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

KPIC 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, KPIC will act to guard against bias and to ensure independence. Accordingly, KPIC 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 KPIC 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 additional information that the IRO must consider when conducting the external review. Additional information must be submitted in writing to the assigned IRO within ten business days following receipt of the notice. 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, KPIC 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 KPIC to timely provide the documents and information will not delay the conduct of the external review. If KPIC 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 KPIC.
- (d) Upon receipt of any information submitted by the claimant, the IRO will within one business day forward the information to KPIC. Upon receipt of any such information, KPIC may reconsider its adverse benefit determination or final internal

adverse benefit determination that is the subject of the external review. Reconsideration by KPIC will not delay the external review. The external review may be terminated because of the reconsideration only if KPIC 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, KPIC 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 KPIC.

- (e) The IRO will review all 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, KPIC 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

KPIC 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, KPIC will determine whether the request meets the reviewability requirements set forth above for standard external review. KPIC 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, KPIC will assign an IRO pursuant to the requirements set forth above for standard review. KPIC 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

KPIC'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. You must commence any legal or equitable action for benefits within two years after the date that notification is sent to the participant or beneficiary (and/or his or her authorized representative) that the adverse benefit determination has been upheld on appeal.

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.

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.

Some individuals may not be qualified beneficiaries for purposes of COBRA continuation unless they meet the federal definition of “qualified beneficiary”. However, most individuals are eligible through your Employer for continuation coverage under the same time conditions and time periods as COBRA.

Secondary Qualifying Events

If, because 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.

CONTINUITY OF CARE

Your Plan uses Network providers to provide Plan benefits. Should a Network Provider contract terminate, Continuing Care Patients, of the terminated provider have a right to elect to continue transitional care from that terminated provider under the same terms and conditions for the earlier of 90-days or until you are no longer a Continuing Care Patient.

- a) A Continuing Care Patient is an individual who, with respect to a provider: Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- b) Is undergoing a course of institutional or inpatient care from the provider or facility;
- c) Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- d) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- e) Is or was determined to be terminally ill (as determined under specified Medicare rules) and is receiving treatment for such illness from such provider or facility.

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 more than 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 www.kp.org.

Service Areas Colorado

County	City
ADAMS	AURORA, BENNETT, BRIGHTON, BROOMFIELD, COMMERCE CITY, DENVER, DUPONT, EASTLAKE, HENDERSON, , THORNTON, WESTMINSTER
ALBANY	JELM
ARAPAHOE	AURORA, BENNETT, DENVER, ENGLEWOOD, LITTLETON, WATKINS
BOULDER	ALLENSPARK, BOULDER, EL DORADO SPRINGS, HYGIENE, JAMESTOWN, LAFAYETTE, LONGMONT, LOUISVILLE, LYONS, NEDERLAND, NIWOT, PINECLIFFE, WARD
BROOMFIELD	BROOMFIELD
CLEAR CREEK	IDAHO SPRINGS
CROWLEY	OLNEY SPRINGS
CUSTER	WETMORE
DENVER	DENVER, LITTLETON
DOUGLAS	CASTLE ROCK, ENGLEWOOD, FRANKTOWN, LARKSPUR, LITTLETON, LONE TREE, LOUVIERS, PARKER, SEDALIA
ELBERT	ELIZABETH, KIOWA
EL PASO	CALHAN, CASCADE, COLORADO SPRINGS, ELBERT, FOUNTAIN, GREEN MOUNTAIN FALLS, MANITOU SPRINGS, MONUMENT, PALMER LAKE, PEYTON, RAMAH, U S A F ACADEMY, YODER,
ELBERT	ELBERT, RAMAH
FREMONT	BROOKSIDE, CANON CITY, COAL CREEK, COALDALE, COTOPAXI, FLORENCE, HILLSIDE, HOWARD, PENROSE, ROCKVALE,
GILPIN	BLACK HAWK, CENTRAL CITY, ROLLINSVILLE
HUERFANO	RYE,
JEFFERSON	ARVADA, BROOMFIELD, BUFFALO CREEK, CONIFER, DENVER, EVERGREEN, GOLDEN, IDLEDALE, INDIAN HILLS, KITTREDGE, LITTLETON, MORRISON, PINE, WHEAT RIDGE
KIMBALL	BUSHNELL, KIMBALL
LARAMIE	PINEBLUFFS
LARIMER	BELLEVUE, BERTHOUD, CARR, DRAKE, ESTES PARK, FORT COLLINS, GLEN HAVEN, LAPORTE, LIVERMORE, LOVELAND, LYONS, MASONVILLE, RED FEATHER LAKES, ROCKY MTN. NATIONAL PARK, SEVERANCE, TIMNATH, VIRGINIA DALE, WELLINGTON, WINDSOR
LINCOLN	RUSH,
MORGAN	HOYT, ORCHARD, WIGGINS
OTERO	FOWLER,
PARK	BAILEY, GUFFEY, LAKE GEORGE, PINE
PUEBLO	AVONDALE, BEULAH, BOONE, COLORADO CITY, PUEBLO, RYE,
TELLER	CRIPPLE CREEK, DIVIDE, FLORISSANT, VICTOR, WOODLAND PARK
WELD	AULT, BRIGGSDALE, BRIGHTON, CARR, DAcono, EATON, ERIE, EVANS, FIRESTONE, FORT LUPTON, FORT MORGAN, FREDERICK, GALETON, GARDEN CITY, GILL, GILCREST, GREELEY, GROVER, HEREFORD, HUDSON, JOHNSTOWN, KEENESBURG, KERSEY, LA SALLE, LONGMONT, LOVELAND, LUCERNE, MEAD, MILLIKEN, NEW RAYMER, NUNN, ORCHARD, PIERCE, PLATTEVILLE, RAYMER, ROGGEN, SEVERANCE, STONEHAM, WINDSOR

SUBMITTING A CLAIM

Network Providers will submit claims on your behalf. Should you receive care from a Non-Network Provider, submit a claim for reimbursement on-line by logging into kp.org then use the search function to search for “claim form”.



Home

Benefits

Visit Cost Summary

Resources

Contact Us

[Return to kp.org](#)

Submit a Claim

Submit Reimbursement for COVID-19 at Home Test Kit

Your reimbursement claim will be processed by the Pharmacy Benefit Manager (OptumRX). You will be the reimbursement request directly on their web portal.

By submitting a claim for reimbursement, you are attesting that the self-test was purchased for personal use, is not for employment purposes unless required by applicable state law, has not and will not be reissued by another source, and is not for resale.

[Submit Reimbursement Claim Online](#)

Submit a Medical Claim

[Submit Medical Claim Online](#)

Or you may print and complete a [Medical Claim Form \(PDF\)](#), then mail to:

Kaiser Permanente Insurance Company (KPIC)
Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547

To view your Medical Claim Online submissions, please click [here](#).

Submit a Pharmacy Claim

[Submit Pharmacy Claim Online](#)

Or you may print and complete a [Standard Pharmacy Claim Form \(PDF\)](#), then mail to:

OptumRx Manual Claims
P.O. Box 650334
Dallas, TX 75265-0335

CONSUMER ASSISTANCE TOOLS

Help In Your language:

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

KPIC:

- Provides no cost auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call: 1-866-213-3062 (TTY: 711)

Attention: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call 1-866-213-3062 (TTY: 711).

አማርኛ (Amharic) ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ተገቢ የሆኑ ረዳት መርጃዎች እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ለእርስዎ ይገኛሉ። ወደ **1-866-213-3062** (TTY: 711) ይደውሉ።

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-213-3062** (TTY: 711).

Հայերեն (Armenian) ՈւՅՄՈՒՄՆԻԹՅՈՒՆ: եթե հայերեն եք խոսում, ձեզ համար մատչելի են լեզվական աջակցության անվճար ծառայություններ, ներառյալ համապատասխան օժանդակ միջոցներ և ծառայություններ: Զանգահարեք **1-866-213-3062** հեռախոսահամարով (TTY 711):

B'aso-Wùdù (Bassa) DYÉDÉ-GBO-DÈ-ÐÈ: Ɔ jù ké m̄ d̄yí B'aso-Wùdù po-nyò jùin, wuɖu-xwiniin mú zàzà b̄è kè gbo-kpá-kpá ɔ kè kùà tòò b̄è se wíqí. péè-péè d̄ò k'óèè ní bó m̄ bìi. Dá **1-866-213-3062** (TTY: 711).

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনি প্রয়োজনীয় সহায়ক উপকরণ ও সেবা, সহ ভাষা পরিষেবা বিনামূল্যে পেতে পারেন। কল করুন **1-866-213-3062** (TTY: 711).

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言協助服務，包括適當的輔助與服務。請致電**1-866-213-3062** (TTY: 711)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید خدمات کمک‌رسانی زبانی، شامل کمک‌ها و خدمات جانبی مناسب، به صورت رایگان در دسترس‌تان قرار می‌گیرد. با شماره **1-866-213-3062** تماس بگیرید (TTY: 711).

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique, notamment des aides et des services auxiliaires adaptés, sont mis gratuitement à votre disposition. Appelez le **1-866-213-3062 (TTY : 711)**.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Bitte wählen Sie die **1-866-213-3062 (TTY: 711)**.

ગુજરાતી (Gujarati) ध्यान राખो: જો તમે ગુજરાતી બોલતા હોવ, તો યોગ્ય સહાયક સહાય અને સેવાઓ, સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કોલ કરો **1-866-213-3062 (TTY: 711)**.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale kreyòl ayisyen, gen sèvis asistans lengwistik ansanm ak èd epi sèvis ki gen rapò ak sa yo, ki disponib pou ou san w p ap peye. Rele **1-866-213-3062 (TTY: 711)**.

हिंदी (Hindi) ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ्त उपलब्ध हैं। **1-866-213-3062 (TTY: 711)** पर कॉल करें।

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus uas pab dawb rau koj. Hu rau **1-866-213-3062 (TTY: 711)**.

Igbo (Igbo) Gee ntị: O buru na ina-asu asusu English, oru enyemaka asusu gunyere oru na enyemaka kwesiri ekwesị, di n'efu, di maka gi. Kpoo **1-866-213-3062 (TTY: 711)**.

Italiano (Italian) ATTENZIONE: Se parla italiano, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiami il numero **1-866-213-3062 (TTY: 711)**.

日本語 (Japanese) お知らせ : 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。電話 : **1-866-213-3062 (TTY: 711)**。

ខ្មែរ (Khmer) សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសា រួមទាំងឧបករណ៍ និងសេវាកម្មជំនួយសមរម្យ ដោយមិនគិតថ្លៃ គឺអាចអនុវត្តបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ **1-866-213-3062 (TTY: 711)**។

한국어 (Korean) 참고: 한국어를 구사하시는 경우, 필요한 보조 기기와 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-866-213-3062(TTY: 711)**번으로 전화하십시오.

ພາສາລາວ (Laotian) ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ວວມທັງຄວາມຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມທຳນຽມຂ້ອງໂດຍບໍ່ເສຍຄ່າ. ໂທຫາ **1-866-213-3062 (TTY: 711)**.

Naabeehó (Navajo) BEE ADIIT'ÁNÍ: T'áá shoodí éí Diné bizaad bee yánilti', t'áá iiyisi dóó ch'iyaán yáhoot'éél nihá shikaadéél dah naashá. Doo baa akót'éego nihá baqah daniidlii'. Háálá **1-866-213-3062 (TTY: 711)**.

नेपाल (Nepali) ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने उपयुक्त सहायक साधनहरू र सेवाहरू सहितको भाषा सहायता सेवा तपाईंको लागि नि:शुल्क उपलब्ध छ। **1-866-213-3062 (TTY: 711)** मा फोन गर्नुहोस्।

Afaan Oromoo (Oromo) FUULEFFANNAA: Afaan Oromoo dubbattu yoo ta'e, tajaajiloonni afaanii meeshaalee fi tajaajiloota qaama miidhamtootaaf mijaa'oo ta'an dabalatee, kaffaltii irraa bilisa karaa ta'een, ni argamu. Bilbilaa **1-866-213-3062 irratti (TTY: 711)**.

Português (Portuguese) ATENÇÃO: Se você fala português, serviços de assistência de idioma, incluindo recursos e serviços auxiliares adequados, estão disponíveis gratuitamente para você. Ligue para 1-866-213-3062 (TTY: 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਢੁਕਵੇਂ ਸਹਾਇਕ ਉਪਕਰਨਾਂ ਸਮੇਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-866-213-3062 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă sunt disponibile în mod gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la numărul 1-866-213-3062 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите по-русски, вы можете получить бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Звоните по телефону 1-866-213-3062 (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen aparatos y servicios auxiliares adecuados y gratuitos. Llame al 1-866-213-3062 (TTY: 711).

Tagalog (Tagalog) PAUNAWA: Kung kayo ay nagsasalita ng Tagalog, ang mga serbisyo ng tulong sa wika, kabilang ang mga naaangkop na karagdagang tulong at serbisyo, na walang bayad, ay available sa inyo. Tumawag sa 1-866-213-3062 (TTY: 711).

ไทย (Thai) หมายเหตุ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือนและบริการเสริมที่เหมาะสมได้ฟรี โปรดติดต่อหมายเลข 1-866-213-3062 (เครื่อง TTY: 711)

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Телефонуйте 1-866-213-3062 (TTY: 711).

اردو (Urdu) توجہ دین: اگر آپ اردو بولتے ہیں تو لسانی اعانت کی خدمات، بشمول مناسب معاون امدادی آلات اور خدمات، بلا معاوضہ، آپ کے لیے دستیاب ہیں۔ 1-866-213-3062 (TTY: 711) پر کال کریں۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu nói tiếng Việt, quý vị có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Gọi số 1-866-213-3062 (TTY: 711).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Bí o bá lè sọ èdè Yorùbá, àwọn ètò irànlọwọ èdè, títi kan àwọn ohun èlò àti isẹ irànlọwọ tó yẹ wà fún ọ lófèfè. Pe 1-866-213-3062 (TTY: 711).

NON-DISCRIMINATION NOTICE

If you believe that KPIC has failed to provide these services or discriminated in another way on the basis of national origin, ancestry, age, disability, sex, religion, creed, or marital status, you can file a grievance by mail or phone with your home region Civil Rights Coordinator office:

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- By completing the complaint form and submitting the form to:

The U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201
Phone: 1-800-368-1019
Phone (TDD): 1-800-537-7697

Complaint forms can be found online: <http://www.hhs.gov/ocr/office/file/index.html>.

- Or, electronically by submitting your complaint through the Office for Civil Rights Complaints Online Portal:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "Balance Billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network and/or your plan does not cover out-of-network Services.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide Services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a Service. This is called "**balance billing**." This amount is likely more than your in-network costs for the same Service and might not count toward your plan's deductible or annual out-of-pocket limit. Your health plan coverage may not cover out-of-network Services when you agree (consent) to receive Services from the out-of-network providers.

What is "Surprise Billing"?

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or Service. Providers and facilities are not balance billing you when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under your plan for the Services that they provided.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency Services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency Services. This includes Services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization Services.

Certain Services at an in-network hospital or ambulatory surgical center

When you get Services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist Services, or when an in-network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of Services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections. **These providers can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency Services without requiring you to get approval for Services in advance (also known as "prior authorization").
 - Cover emergency Services by out-of-network providers and facilities.
 - Base what you owe the provider or facility (your cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency Services or non-emergency Services provided by certain out-of-network providers at an in-network facility toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by a provider or facility, contact the federal government at: 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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: 7/1/2026 – 6/30/2027

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	\$10,600	
Per Family	\$21,200	
The out-of-pocket limit is the most you could pay in a year for covered Services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.		
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)	\$0	No
Wellness Exams – Children	\$0	No
Preventive Screenings Immunizations	\$0	No
(Preventive) Adults and Children. Health Education	\$0	No
and Self-Management Classes	\$0	No
Annual mental wellness exam Limited to one per year	\$0	No
OUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, any Non-Inpatient setting)		
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. Note: Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.		
Office Visits , Including House Calls		
Primary Care	\$30	Yes
Specialty Care	\$40	Yes
Referred Hospital Clinic Visits		
Primary Care	\$30	Yes
Specialty Care	\$40	Yes
Facility Clinic Charges	\$0	Yes
Telemedicine Telephone, Video or Chat / Online communications	\$0	Yes

Benefit Type	You Pay and/or Maximums	Applies to OOP
Allergy Office visit cost share may apply Injection Testing Serum Only	\$10 \$40 \$0	Yes Yes Yes
Biofeedback Services Medical and Mental Health Services	\$30	Yes
Cardiac Rehab Primary Care Specialty Care	\$30 \$40	Yes Yes
Chemotherapy Services Injection	\$40 \$40	Yes Yes
Dialysis Services Home Dialysis	\$40 \$0	Yes Yes
Hearing Exam Audiometry exam Primary Care (Audiologist) Specialty Care (Otolaryngologist)	\$30 \$40	Yes Yes
Infusion Services Requires skilled or medical administration. Office visit cost share may apply. Infusion Primary Care Infusion Specialty Home Infusion, Infusion materials, drugs and supplies	\$30 \$40 \$0	Yes Yes Yes
Injections and Immunizations Non-routine Office visit cost share may apply Injection Primary Care Injection Specialty Care Epidural Steroid Injections	\$30 \$40 \$250	Yes Yes Yes
Travel Immunizations Office visit cost share may apply. Injection	\$0	Yes
Male Sterilization Outpatient Surgery	\$0	Yes
Nutrition Counseling Primary Care Specialty Care	\$30 \$40	Yes Yes
Pulmonary Therapy 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
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process. UV Light Therapy (in the Office) Office Visit Cost Share may apply) UV Light Therapy Box (for Home Use)	\$30 \$0	Yes Yes
Vision Exam Optometrist Ophthalmologist NOTE: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty.	\$30 \$40	Yes Yes
Weight Loss – For 18 years and over of age	\$0	Yes

HOSPITAL / SURGERY SERVICES		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Inpatient Hospital Includes room and board for semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Ancillary Services, Supplies. Per day Inpatient Hospital limit per admission	\$250 \$1,000	Yes Yes
Ambulance Emergency Ground and Air Ambulance Scheduled Ground and Air Ambulance Non-Network Hospital to Network hospital (repatriation)	\$0 \$0 \$0	Yes Yes Yes
Emergency Services Accident and Illness. High-cost radiology procedure Cost Share is applied in addition to ED Cost Share Copayment waived if admitted.	\$250 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, Transurethral Microwave Therapy, Endometrial Ablation with Hysteroscopy, Fistulization Sclera (Trabeculectomy with Mytomycin)	\$250	Yes
Colonoscopy (all non-inpatient places of Service)	\$0	Yes
Abortion Office Visit Lab & X-ray Outpatient Surgery Inpatient Hospital limit per admission	\$0 \$0 \$0 \$0	Yes Yes Yes Yes
Bariatric Surgery Office Visit Outpatient Surgery Inpatient Hospital per day	\$ 4 0 3 0 % 30%	Yes Yes Yes
Gender Affirming Surgery Upper and lower body gender affirming surgeries Outpatient Surgery Inpatient Hospital per day Inpatient Hospital limit per admission Benefit Lifetime Maximum	\$250 \$250 \$1,000 Unlimited	Yes Yes Yes N/A
Temporomandibular Surgery (TMD/TMJ) Office Visit Outpatient Surgery Inpatient Hospital per day Inpatient Hospital limit per admission	\$40 \$250 \$250 \$1,000	Yes Yes Yes Yes
Organ Transplants Organ acquisition, diagnostic testing for donor and recipient Office Visit Outpatient Surgery Inpatient Hospital per day Inpatient Hospital limit per admission	\$40 \$250 \$250 \$1,000	Yes Yes Yes Yes

MATERNITY Includes most Routine Pre-Natal and Post-Partum care. Delivery charges and Non-routine Maternity Care and Routine Care not included under preventive Care would be covered at the appropriate cost share.		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Routine Pre-Natal and Post-Partum Care Pre-natal and post-partum visits	\$0	No
Home Perinatology Visits Primary Care Specialty Care	\$30 \$40	Yes Yes
Hospital Inpatient Includes contracted Birthing Center if available Per day Inpatient Hospital limit per admission Professional Well Newborn	\$250 \$1,000 \$0 \$0	Yes Yes Yes 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 & X-ray	\$0	Yes
Diagnostic Tests performed in the Office Primary Care Specialty Care	\$30 \$40	Yes Yes
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine & PET per procedure	\$100	Yes
FERTILITY SERVICES Services for Fertility include those related to or part of Artificial Insemination Surgery, IVF, ZIFT, GIFT and Fertility Drugs. Services to rule out the underlying medical causes of Infertility and iatrogenic fertility preservation and storage are part of the medical benefit. Fertility drugs (see Pharmacy section).		
Hospital Charges Per day Inpatient Hospital limit per admission Office Visit	\$250 \$1,000 \$40	Yes Yes Yes
Diagnostic Lab & X-ray Outpatient hospital or Ambulatory Surgery Center (ASC) Artificial Insemination Assistive Reproductive Technology (ZIFT and IVF) Fertility Preservation (Elective for medical and non-medical reasons or iatrogenic), cryopreservation storage of eggs and sperm retrieved Fertility Preservation Storage (Up to one year for medical reasons (e.g. cancer or gender affirming))	\$0 \$250 \$250 \$250 \$250 \$250	Yes Yes Yes Yes Yes Yes
MENTAL HEALTH & SUBSTANCE USE DISORDER		
Mental Health - Inpatient Includes Residential Treatment Per day Inpatient Hospital limit per admission	\$250 \$1000	Yes Yes
Partial Hospitalization Per day Mental Health - Intensive Outpatient, per day Includes all Services provided during the day	\$0 \$0	Yes Yes
Mental Health – Outpatient/Office Cost share may also apply to office visits with MH/SUD diagnoses. Individual Visit Cost Share Group Visit Cost Share	\$30 \$15	Yes Yes

Benefit Type	You Pay and/or Maximums	Applies to OOP
Substance Use Disorder - Inpatient and Residential Treatment Detox covered under-medical benefits Per day Inpatient Hospital limit per admission	\$250 \$1000	Yes Yes
Substance Use Disorder - Partial Hospitalization Per day Substance Use Disorder - Intensive Outpatient, per day Includes all Services provided during the day.	\$0 \$0	Yes Yes
Substance Use Disorder – Outpatient/Office Cost share may also apply to office visits with MH/SUD diagnoses. Individual Visit Cost Share Group Visit Cost Share	\$30 \$15	Yes Yes
MULTIDISCIPLINARY REHABILITATION - Organized Multidisciplinary Service program in a designated or Skilled Nursing Facility.		
Inpatient Hospital Per day Inpatient Hospital limit per admission	\$250 \$1000	Yes Yes
Outpatient Rehab Therapy Limits	\$30 Unlimited	Yes N/A
* Visit limits apply to Members eligible for Early Intervention Services after separate EIS visits are exhausted.		
PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES – Cost Share for Rehabilitative and Habilitative therapies are applied as one copay per provider per day. Visits are counted on a ‘per visit’ basis. (Includes: Therapies for Congenital Defects and Birth Abnormalities and Early Intervention Services Provided by Kaiser).		
Physical Therapy Visit Maximum Visit limits do not apply for the treatment of autism	\$30 20 Rehabilitative visits per Plan year* 20 Habilitative visits per Plan Year*	Yes N/A
Occupational Therapy Visit Maximum Visit limits do not apply for the treatment of autism	\$30 20 Rehabilitative visits per Plan year* 20 Habilitative visits per Plan Year*	Yes N/A
Speech Therapy Visit Maximum Visit limits do not apply for the treatment of autism	\$30 20 Rehabilitative visits per Plan year* 20 Habilitative visits per Plan Year*	Yes N/A
EARLY INTERVENTION SERVICES (EIS) Provided through a CCB (Community Centered Board) 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 Plan year maximum combined with social, educational, nutritional and other Services.	\$0 55 visits per plan year	Yes N/A

SKILLED CARE		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Home Health Care 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	\$0 Unlimited	Yes N/A
Hospice Hospital Inpatient Home Based	\$0 \$0	Yes Yes
Hospice Special Services Program Respite Services- Home Based Respite Services- Hospital Inpatient	\$0 \$0	Yes Yes
Skilled Nursing Facility Per day Day Maximum	\$0 100 days per Plan year	Yes N/A
OTHER SERVICES		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Acupuncture Self referred visits (to any willing provider including Out of Network) Visit Maximum	\$30 20 visits per contract year	Yes N/A
Chiropractic Care Self referred visits with a Network or contracted provider Visit Maximum	\$30 20 visits per contract year	Yes N/A
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury	Not covered	N/A
Autism A diagnosis of ASD is required for benefits to apply toward the maximum benefit amount. Applied Behavioral Analysis Physical/Occupational/Speech Therapy Visit maximum	\$30 \$30 Unlimited	Yes Yes N/A
Benefit Type	You Pay and/or Maximums	Applies to OOP
Durable Medical Equipment Including Diabetic testing supplies and equipment <i>Colorado DME/P&O formulary applies</i>	\$0	Yes
Breast Feeding Pump	\$0	Yes
Medical Foods Amino acid modified products. Per product per day	\$0	Yes
Oxygen	\$0	Yes
Prosthetics and Orthotics Includes colostomy/ostomy and urological supplies.	\$0	Yes
Hearing Aids - Initial and replacement hearing aids for minor children with a verified hearing loss.	\$0	Yes
Age Limits	Persons under the age of 18 years	N/A
Benefit Limits	Two hearing aids for each ear every 60 months unless alterations to existing hearing aid cannot adequately meet the needs of the child	N/A
VISION HARDWARE - Frames and Eyeglass Lenses or Contact Lenses		
Vision Hardware - Contact Lenses	Not Covered	N/A
Vision Hardware - Frames and Eyeglass Lenses	Not covered	N/A

OUT OF AREA BENEFIT (for dependents only): Coverage for pharmacy, routine, and follow-up care Outside the Service Area (within the U.S.)

Benefit Type	You Pay and/or Maximums	Applies to OOP
Office Visit Primary care, Specialty, Mental Health/Chemical Dependency, Well Child prevention, Gyn and Allergy injection visits, Immunizations are covered. All other visits not covered.	\$30	Yes
Office Visit limits (procedures and labs are excluded)	Up to 10 per plan year	N/A
Flu shots	\$0	No
Diagnostic X-ray Service (X-ray and Ultrasound only)	20%	Yes
Diagnostic X-ray Service limits (X-ray and Ultrasound only)	Up to 10 per plan year	N/A
Physical, Occupational & Speech Therapies	\$30	Yes
Visit Maximum	Up to 10 combined physical, occupational and speech therapy visits per plan year	N/A
Prescription Drugs ACA Mandated Drugs*	Applicable cost share applies	Yes
Diabetic testing supplies (meters, test strips)	\$0	No
	\$0	Yes

TRAVEL AND LODGING For reasonable transportation and lodging that is primarily for and essential to receipt of a specific Covered Service where (1) the covered individual is unable to locate an In-Network provider in the State where the covered individual resides and (2) the covered individual must travel more than 50 miles to receive the Covered Service.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Kaiser Permanente coordinated Travel and Lodging for Organ Transplants Organ Transplants include recipient, care giver and donor		
Transportation Limits	Unlimited	N/A
Lodging Limits	Unlimited	N/A
Daily Expense Limits Daily expenses include incidental expenses such as meals and does not include personal expenses. Benefit Maximum	Reimbursement of up to \$50 per day per person	N/A
Benefit Lifetime Maximum	Unlimited	N/A
Member Reimbursed Travel and Lodging - For other covered services not offered within 50 miles of your residence. Includes patient and medically necessary companion. International travel is excluded.		
Transportation Limits Includes round trip transportation and lodging for the patient and one adult companion • Travel in a personal car, at the current IRS standard mileage rate • Economy class air or train fare • Public transportation, taxis, Lyft, Uber, or similar services (Limos, luxury or upgraded vehicles will not be reimbursed) • Parking and tolls	Unlimited	N/A
Lodging Limits Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure. Reimbursement is limited to the charge for a single (double occupancy) room, including taxes, not to exceed \$50/night per person up to 2 people, for 1 or 2 nights as required, unless a longer stay was recommended by a physician. (Hotel movies, entertainment, meals, and other services will not be reimbursed.)	\$50 per night, \$100 per night if accompanied by a companion	Yes
Daily expenses Includes incidental expenses such as meals and other personal expenses.	Not covered	N/A
Benefit Maximum	Unlimited	N/A
Benefit Lifetime Maximum	Unlimited	N/A

Reimbursement for reasonable transportation and lodging expenses actually incurred by you and a companion in the course of obtaining the covered service. Services must be received at the most reasonable provider for the service provided.

OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified. Note: Member will pay their copay or the full cost of the medication, whichever is less.		
Benefit Type	You Pay and/or Maximums	Applies to OOP
Generic - Per Prescription Maximum	\$10 up to 30-day supply	Yes
Specialty Rx - Per Prescription Maximum	20% for specialty Rx, including Self- Administered injectables, up to a maximum of \$100 per Rx, up to 30-day supply	Yes
Brand - Per Prescription Maximum	\$50 up to 30-day supply	Yes
Note: Certain medications may be limited to 30-day supply		
Mail Order Drugs		
Generic - Per Prescription Maximum	\$10 up to 30-day supply and \$20 from 31 up to 90-day supply	Yes
Specialty Rx- Per Prescription Maximum	20% for specialty Rx, including Self- Administered injectables, up to a maximum of \$100 per Rx, up to 30-day supply	Yes
Brand - Per Prescription Maximum	\$50 up to 30-day supply and \$100 from 31 up to 90-day supply	Yes
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order		
Blood Factors	\$0	Yes
Diabetic Coverage – Some diabetic supplies may be covered under Durable Medical Equipment		
Insulin and Generic medications	\$0	Yes
Diabetic testing supplies (meters, test strips)	\$0	Yes
Diabetic administration devices (syringes)	\$0	Yes
Fertility Drug Coverage	=Generic/Brand/Specialty Cost Share	Yes
Sexual Dysfunction	Not covered	N/A
Weight Loss	Not covered	N/A
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis and stroke	\$0	Yes
ACA Mandated Drugs* (see Preventive Services for more information)		
Contraceptive Devices (diaphragms, cervical caps, etc.) methods and Contraceptive Drugs (FDA approved and prescribed by your doctor)	\$0	No
Emergency Contraception	\$0	No
Preventive Breast Cancer Drugs	\$0	No
Smoking Cessation	\$0	No
Statins (Cholesterol Lowering Agents)	\$0	No
PrEP for HIV Prevention	\$0	No
Preventive Over the Counter Products - Preventive Over the Counter products are covered at a network pharmacy when prescribed by your provider for certain conditions.		
Aspirin	\$0	No
Oral Fluoride	\$0	No
Folic Acid	\$0	No
Iron Supplements	\$0	No
Female Contraceptives (spermicides, male and female condoms and sponges)	\$0	No
Bowel Prep (for Colonoscopies)	\$0	No
* With prescription, no cost share. Without prescription, Participant pays retail cost		
Refer to the Outpatient Prescription Drug section later in this document for coupon information.		
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.		