DENVER PUBLIC SCHOOLS

2023 Summary Plan Description

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

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Introduction

This is not an insured benefit plan. Plan benefits are self-insured by Denver Public Schools, which is responsible for their payment. Kaiser Permanente Insurance Company provides only administrative services on behalf of the Plan and does not insure the Plan benefits.

Denver Public Schools (the "Plan Sponsor") is pleased to sponsor a medical plan known as the Denver Public Schools Health Plan (the "Plan").

The Plan covers and pays for the benefits described in this Benefit 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 Benefit 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 Benefit Booklet is not the complete official Plan document. If there is a conflict between the Plan document and this Benefit 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 (EPO) plan. Therefore, you must receive all Covered Services from Network Providers, except you can receive covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent 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.**

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

Language Assistance

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

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

Schedule of Benefits

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, General Limitations, Coordination of Benefits, and Reductions" section of this Benefit Booklet.

Denver Public Schools

Colorado Benefit Summary
KP Use only: Plan IDs: S0290
Effective Date: 07/01/2023

This is a summary of Benefits for your Kaiser Permanente DEPO Plan

OVERALL PLAN FEATURES

Plan Accumulation Type	Plan Year	
Plan Deductible Individual Family	 **$1,000** **$3,000**	
Embedded Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.		
Plan Deductible Accumulates to Out-of-Pocket Maximum	**Yes**	
4th Quarter Carry Over	**No**	
Annual Out-of-Pocket Maximum Individual Family	 **$3,000** **$9,000**	
Embedded 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.		

Copays: One Copay 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 Preventive Services Listing, Screenings and Immunizations for a comprehensive list of Covered Services. Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings 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	Subject to Deductible	Applies to OOP
Wellness Exams – Adults (Including *Well Woman*)	**$0**	**No**	**No**
Mammograms			
Preventive	**$0**	**No**	**No**
Diagnostic	**30%**	**Yes**	**Yes**
Note: If your first mammogram of the Plan Year is Diagnostic, it will be covered at $0, not subject to deductible. Please refer to your SPD for more information.			
Wellness Exams – Children	**$0**	**No**	**No**
Preventive Screenings	**$0**	**No**	**No**
Immunizations (Preventive) *Adults and Children.*	**$0**	**No**	**No**
Health Education and Self-management Classes	**$0**	**No**	**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 except Mental Health providers are considered to be Primary Care providers for the purposes of determining Participant cost share. **Note:** Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Office Visits *Including House Calls*			
Primary Care	**$40**	**No**	**Yes**
Specialty Care	**$60**	**No**	**Yes**
Procedures in the Office	**30%**	**Yes**	**Yes**
Referred Hospital Clinic Visits			
Provider	**$40**	**No**	**Yes**
Facility Clinic Charges	**30%**	**Yes**	**Yes**
Telemedicine *Telephone, Video, or Chat/Online communications*	**$0**	**No**	**Yes**
Allergy *Office Visit cost share may apply*			
Injection	**$40**	**No**	**Yes**
Testing	**$40**	**No**	**Yes**
Serum only	**$0**	**No**	**Yes**
Biofeedback Services *Medical and Mental Health Services*	**$40**	**No**	**Yes**
Cardiac Rehab			
Primary Care	**$40**	**No**	**Yes**
Specialty Care	**$60**	**No**	**Yes**
Chemotherapy Services	**30%**	**Yes**	**Yes**
Dialysis Services	**$60**	**No**	**Yes**
Home Dialysis	**$0**	**No**	**Yes**
Hearing Exam *Audiometry exam and medical exam*			
Audiologist	**$40**	**No**	**Yes**
Otolaryngologist	**$60**	**No**	**Yes**
Infusion Services *Requires skilled or medical administration. Office Visit cost share may apply.*			
Infusion	**30%**	**Yes**	**Yes**
Home Infusion *Infusion materials, drugs, and supplies*	**30%**	**Yes**	**Yes**
Injections and Immunizations *Non-routine Office Visit cost share may apply.*			
Injection	**30%**	**Yes**	**Yes**
Epidural Steroid Injections	**30%**	**Yes**	**Yes**
Travel immunizations *Office Visit cost share may apply*			
Injection	**Not Covered**	**N/A**	**N/A**
Male Sterilization			
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**$500**	**No**	**Yes**
Nutrition Visits			
Primary Care	**$40**	**No**	**Yes**
Specialty Care	**$60**	**No**	**Yes**

OUTPATIENT SERVICES cont.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Pulmonary Rehab	**$40**	**No**	**Yes**
Limits	**None**		
Radiation Therapy	**30%**	**Yes**	**Yes**
Respiratory Therapy	**$60**	**No**	**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)*	**$0**	**No**	**Yes**
UV Light Therapy Box *(for Home Use)*	**30%**	**No**	**Yes**
Vision Refraction Exam			
Office Visit – Optometrist	**$40**	**No**	**Yes**
Office Visit – Ophthalmology	**$60**	**No**	**Yes**
Note: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty			

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Inpatient Hospital *Includes room and board for semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Ancillary Services, and Supplies. Additional cost for private rooms is not covered unless Medically Necessary.*			
Per admission	**30%**	**Yes**	**Yes**
Ambulance			
Emergency Ground and Air Ambulance	**30%**	**No**	**Yes**
Per trip Cost Share limit	***up to $500 per trip***	**No**	**Yes**
Scheduled Ground and Air Ambulance	**30%**	**No**	**Yes**
Per trip Cost Share limit	***up to $500 per trip***	**No**	**Yes**
Non-Network or Network Hospital to Network Hospital *(repatriation)*	**$0**	**No**	**Yes**
Emergency Services *Accident and Illness. High Tech radiology procedure Cost Share is applied in addition to Emergency Cost Share*	**30%**	**Yes**	**Yes**
Urgent and After-Hours Care *Urgent Care and After-Hours settings*	**$60**	**No**	**Yes**
Urgent Procedures	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**$500**	**No**	**Yes**
Abortion *Elective, Medically Necessary*			
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**$500**	**No**	**Yes**
Inpatient Hospital per admission	**30%**	**Yes**	**Yes**
Bariatric Surgery	**Not Covered**	**N/A**	**N/A**
Temporomandibular Surgery (TMD/TMJ)			
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**$500**	**No**	**Yes**
Inpatient Hospital per admission	**30%**	**Yes**	**Yes**

HOSPITAL / SURGERY SERVICES cont.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Gender Affirming Surgery *Covered upper and lower body gender affirming surgeries.*			
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**$500**	**No**	**Yes**
Inpatient Hospital per admission	**30%**	**Yes**	**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.*			
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 milage 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*	**None**	**N/A**	**N/A**
Lodging Limits *Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure 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. Does not include meals, international travel, hotel movies, entertainment, or any other services not specifically listed.*	**$50 per night, $100 per night if accompanied by a companion**	**N/A**	**N/A**
Daily Expense *Includes incidental expenses such as meals and does not include personal expenses.*	**Not Covered**	**N/A**	**N/A**
Benefit Lifetime Maximum	**None**	**N/A**	**N/A**

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**	**Subject to Deductible**	**Applies to OOP**
Routine Pre-Natal and Post-Partum Care			
Pre-natal and post-partum visits	**30%**	**Yes**	**Yes**
Home Perinatology Visits	**$60**	**No**	**Yes**
Hospital Inpatient Includes Planned Birthing Center if available			
Per admission (facility) Includes Well baby facility fees when billed with mother	**30%**	**Yes**	**Yes**
Well Newborn	**30%**	**Yes**	**Yes**

DIAGNOSTIC TESTS & PROCEDURES

Includes Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings: These services are treated the same as Lab and X-ray Services in this section.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Diagnostic Lab *Performed in the Office or Independent Lab*	**$0**	**No**	**Yes**
Diagnostic Lab *Performed in an Outpatient Facility and Urgent or After-Hours Care*	**30%**	**Yes**	**Yes**
Diagnostic Tests	**30%**	**Yes**	**Yes**
Diagnostic X-ray	**30%**	**Yes**	**Yes**
High Tech/Advanced Radiology – CT, MRI, Nuclear Medicine and PET	**30%**	**Yes**	**Yes**
Mammograms			
Preventive	**$0**	**No**	**No**
Diagnostic	**30%**	**Yes**	**Yes**

Note: If your first mammogram of the Plan Year is Diagnostic, it will be covered at $0, not subject to deductible. Please refer to your SPD for more information.

FERTILITY SERVICES

Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT, IVF and Fertility Drugs. Services to rule out the underlying medical causes of Infertility are part of the medical benefit. Fertility drugs (see Pharmacy section) and ZIFT and IVF are not covered.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Hospital Charges			
Per admission	**Not Covered**	**N/A**	**N/A**

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Mental Health – Inpatient and Residential Treatment			
Per admission	**30%**	**Yes**	**Yes**
Partial Hospitalization			
Per day	**$40**	**No**	**Yes**
Mental Health – Intensive Outpatient, Per day *Includes all Services provided during the day*	**$40**	**No**	**Yes**
Mental Health – Outpatient/Office			
Individual Visit Cost Share	**$40**	**No**	**Yes**
Group Visit Cost Share	**$20**	**No**	**Yes**
Substance Use Disorder – Inpatient and Residential Treatment *Detox covered under medical benefits*			
Per admission	**30%**	**Yes**	**Yes**
Substance Use Disorder – Partial Hospitalization			
Per day	**$40**	**No**	**Yes**
Substance Use Disorder – Intensive Outpatient, Per day *Includes all Services provided during the day*	**$40**	**No**	**Yes**
Substance Use Disorder – Outpatient/Office			
Individual Visit Cost Share	**$40**	**No**	**Yes**
Group Visit Cost Share	**$20**	**No**	**Yes**

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

For Rehabilitative and Habilitative Care (Includes: Therapies for Congenital Defects and Birth Abnormalities and Early Intervention Services Provided by Kaiser), Outpatient Cost Share for therapies is applied on a one Copayment per provider per day basis. Outpatient Cost Share for therapies is applied on a one Copay per provider per day basis.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Physical Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**$40** *60 visits per Plan year* (Visits are combined between therapies)*	**No**	**Yes**
Occupational Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**$40** *60 visits per Plan year* (Visits are combined between therapies)*	**No**	**Yes**
Speech Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**$40** *60 visits per Plan year* (Visits are combined between therapies)*	**No**	**Yes**
Visit limits apply to Members eligible for Early Intervention Services (EIS) after separate EIS visits are exhausted.			

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 Annual maximum *Combined with social, educational, nutritional, and other Services.*	**$0** *45 visits per Plan year*	**No**	**Yes**

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Subject to Deductible	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	**30%** **Unlimited**	**Yes**	**Yes**
Hospice			
Hospital Inpatient	**30%**	**Yes**	**Yes**
Home Based	**$0**	**No**	**Yes**
Respite Services – Hospital Inpatient	**30%**	**Yes**	**Yes**
Respite Services – Home Based	**$0**	**No**	**Yes**
Hospice Special Services Program	**$0**	**No**	**Yes**
Skilled Nursing Facility Per admission Day maximum	**30%** *100 days per Plan year*	**Yes**	**Yes**

OTHER SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Acupuncture *Self-referred*	**Not Covered**	**N/A**	**N/A**
Acupuncture *Medically refereed for Nausea, Pain Management*	**Not Covered**	**N/A**	**N/A**
Chiropractic Care *(Self-referred Visits with a Network or Planed provider)* Visit maximum	**$40** *25 visits per Plan year*	**No**	**Yes**
Massage Therapy	**Not Covered**	**N/A**	**N/A**
Accidental Injury to Teeth *Repair of sound and natural teeth directly related to an accidental injury.*	**Not covered**	**N/A**	**N/A**

OTHER SERVICES cont.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Autism *A diagnosis of Autism Spectrum Disorder (ASD) is required for benefits to apply toward the maximum benefit amount.*			
Applied Behavioral Analysis	**$40**	**No**	**Yes**
Physical/Occupational/Speech Therapy	**$40**	**No**	**Yes**
Visit maximum	**None**		
Durable Medical Equipment (DME)			
Colorado DME/P&O formulary applies	**30%**	**No**	**Yes**
DME Base items in the office	**$0**	**No**	**Yes**
Oxygen	**30%**	**No**	**Yes**
Prosthetics and Orthotics (P&O)	**20%**	**No**	**Yes**
Hearing Aids – (For age 18 and younger) *Initial and replacement hearing aids for minor children with a verified hearing loss.*	**30%**	**Yes**	**Yes**
Benefit Limits	*One hearing aid, per ear, every 60 months unless alterations to existing hearing aid cannot adequately meet the needs of the child*		
Hearing Aids – Adults	**Not covered**	**N/A**	**N/A**
Medical Foods *Amino acid modified products*	**$0**	**No**	**Yes**
Vision Hardware – Frames and Eyeglass Lenses or Contact Lenses (For age 19 and older)	**Not covered**	**N/A**	**N/A**
Vision Hardware – Frames and Eyeglass Lenses or Contact Lenses (For age 18 and younger) *Includes fitting exam*	**Not covered**	**N/A**	**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.)			
Office Visit *Primary care, Specialty, Mental Health/Chemical Dependency, Well Child prevention, Gyn and Allergy injection visits are covered. All other visits not covered.*	**$40**	**No**	**Yes**
Visit Maximum *(Procedures and labs are excluded)*	*5 visits per Plan year*		
Diagnostic X-ray *(X-ray and Ultrasound only)*	**20%**	**Yes**	**Yes**
Visit Maximum *(X-ray and Ultrasound only)*	*5 visits per Plan year*		
Physical, Occupational & Speech Therapies	**$40**	**No**	**Yes**
Visit Maximum	*5 combined physical, occupational and speech therapy visits per Plan year*		
Prescription Drug	**50%**	**No**	**Yes**

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	Subject to Plan Deductible	Applies to Plan OOP
3 Tier			
Generic	*$20 up to 30 days' supply, $40 31-60 days' supply, $60 61-90 days' supply*	**No**	**Yes**
Brand	*$40 up to 30 days' supply, $80 31-60 days' supply, $120 61-90 days' supply*	**No**	**Yes**
Non-Formulary Brand	*$60 up to 30 days' supply, $120 31-60 days' supply, $180 61-90 days' supply*	**No**	**Yes**
Specialty Rx *(Including self-administered injectables)*	*20% per fill, up to 30 days' supply*	**No**	**Yes**
Per Prescription Maximum	**$250**	**N/A**	**N/A**
Note: Certain medications may be limited to 30-day supply.			
Mail Order Drugs			
3 Tier Mail Order			
Generic	*$20 up to 30 days' supply and $40 from 31 up to 90 days' supply*	**No**	**Yes**
Brand	*$40 up to 30 days' supply and $80 from 31 up to 90 days' supply*	**No**	**Yes**
Non-Formulary Brand	*$60 up to 30 days' supply and $120 from 31 up to 90 days' supply*	**No**	**Yes**
Note: Certain medications may be limited to 30 day supply. Not all medications are available via Mail Order.			
Blood Factors	**$0**	**No**	**Yes**
Diabetic Coverage *Some diabetic supplies may be covered under Durable Medical Equipment.*			
Oral medications and Insulin	**Pays under applicable tier**	**No**	**Yes**
Diabetic testing supplies *(meters, test strips)*	**20%**	**No**	**Yes**
Diabetic administration devices *(syringes)*	**20%**	**No**	**Yes**
Fertility Drug Coverage	**Not covered**	**N/A**	**N/A**
Sexual Dysfunction	**Not covered**	**N/A**	**N/A**
Weight Loss	**Not covered**	**N/A**	**N/A**
Supplemental Preventive Drugs *Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis, and stroke*	*$0 up to 90 days' supply*	**No**	**No**
ACA Mandated Drugs* *(See Preventive Services for more information)*			
Contraceptive Devices *(diaphragms, cervical caps, etc.)* **and Contraceptive Drugs** (FDA approved and prescribed by your doctor)	**$0**	**No**	**No**
Emergency Contraception*	**$0**	**No**	**No**
Preventive Breast Cancer Drugs	**$0**	**No**	**No**
Smoking Cessation	**$0**	**No**	**No**
Statins *(Cholesterol Lowering Agents)*	**$0**	**No**	**No**
PrEP for HIV Prevention	**$0**	**No**	**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**	**No**
Oral Fluoride	**$0**	**No**	**No**
Folic Acid	**$0**	**No**	**No**
Iron Supplements	**$0**	**No**	**No**
Female Contraceptives *(Spermicides, male and female condoms, emergency contraceptives and sponges)*	**$0**	**No**	**No**
Bowel Prep	**$0**	**No**	**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.			
Items or Injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.), office visit for administration will also apply.			

Denver Public Schools

Colorado Benefit Summary
KP Use only: Plan IDs: H0225, H0228
Effective Date: 07/01/2023

This is a summary of Benefits for your Kaiser Permanente High Deductible Health Plan (HDHP)

OVERALL PLAN FEATURES

	HDHP 1500	
Plan Accumulation Type	Plan Year	
Plan Deductible		
Individual	**$1,500**	
Family	**$3,000**	
Aggregate Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.		
Plan Deductible Accumulates to Out-of-Pocket Maximum	**Yes**	
4th Quarter Carry Over	**No**	
Annual Out-of-Pocket Maximum		
Individual	**$3,000**	
Family	**$6,000**	
Aggregate 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.		

Copays: One Copay 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 Preventive Services Listing, Screenings and Immunizations for a comprehensive list of Covered Services. Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings 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	Subject to Deductible	Applies to OOP
	HDHP 1500		
Wellness Exams – Adults (Including *Well Woman*)	**$0**	**No**	**No**
Mammograms			
Preventive	**$0**	**No**	**No**
Diagnostic	**20%**	**Yes**	**Yes**
Note: If your first mammogram of the Plan Year is Diagnostic, it will be covered at $0, not subject to deductible. Please refer to your SPD for more information.			
Wellness Exams – Children	**$0**	**No**	**No**
Preventive Screenings	**$0**	**No**	**No**
Immunizations (Preventive) *Adults and Children.*	**$0**	**No**	**No**
Health Education and Self-management Classes	**$0**	**No**	**No**

OUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, or 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 except Mental Health providers are considered to be Primary Care providers for the purposes of determining Participant cost share. **Note:** Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
Office Visits *Including House Calls*			
Office Visit	**20%**	**Yes**	**Yes**
Referred Hospital Clinic Visits			
Provider	**20%**	**Yes**	**Yes**
Facility Clinic Charges	**20%**	**Yes**	**Yes**
Telemedicine *Telephone, Video, or Chat/Online communications*	**$0**	**No**	**Yes**
Allergy *Office Visit cost share may apply*			
Injection	**20%**	**Yes**	**Yes**
Testing	**20%**	**Yes**	**Yes**
Serum only	**$0**	**Yes**	**Yes**
Biofeedback Services *Medical and Mental Health Services*	**20%**	**Yes**	**Yes**
Cardiac Rehab	**20%**	**Yes**	**Yes**
Chemotherapy Services	**20%**	**Yes**	**Yes**
Provided during an Office Visit	**20%**	**Yes**	**Yes**
Dialysis Services	**20%**	**Yes**	**Yes**
Home Dialysis	**$0**	**Yes**	**Yes**
Hearing Exam *Audiometry exam and medical exam*			
Audiologist	**20%**	**Yes**	**Yes**
Otolaryngologist	**20%**	**Yes**	**Yes**
Infusion Services *Requires skilled or medical administration.* *Office Visit cost share may apply.*			
Infusion	**20%**	**Yes**	**Yes**
Home Infusion *Infusion materials, drugs, and supplies*	**20%**	**Yes**	**Yes**
Injections and Immunizations *Non-routine Office Visit cost share may apply.*			
Injection	**20%**	**Yes**	**Yes**
Travel immunizations *Office Visit cost share may apply*			
Injection	**Not Covered**	**N/A**	**N/A**
Male Sterilization			
Outpatient Surgery *Performed in an Outpatient Hospital*	**20%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**10%**	**Yes**	**Yes**

OUTPATIENT SERVICES cont.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Nutrition Visits			
Office Visit	**20%**	**Yes**	**Yes**
Pulmonary Rehab	**20%**	**Yes**	**Yes**
Limits	**None**		
Radiation Therapy	**20%**	**Yes**	**Yes**
Respiratory Therapy	**20%**	**Yes**	**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)*	**20%**	**Yes**	**Yes**
UV Light Therapy Box *(for Home Use)*	**20%**	**Yes**	**Yes**
Vision Refraction Exam			
Office Visit	**20%**	**Yes**	**Yes**
Note: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty			

HOSPITAL / SURGERY SERVICES			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
	HDHP 1500		
Inpatient Hospital *Includes room and board for semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Ancillary Services, and Supplies. Additional cost for private rooms is not covered unless Medically Necessary.*			
Per admission	**20%**	**Yes**	**Yes**
Ambulance			
Emergency Ground and Air Ambulance	**20%,**	**Yes**	**Yes**
Per trip Cost Share limit	***up to $500 per trip***	**Yes**	**Yes**
Scheduled Ground and Air Ambulance	**20%,**	**Yes**	**Yes**
Per trip Cost Share limit	***up to $500 per trip***	**Yes**	**Yes**
Non-Network or Network Hospital to Network Hospital *(repatriation)*	**$0**	**No**	**Yes**
Emergency Services *Accident and Illness. High tech radiology procedure Cost Share is applied in addition to ED Cost Share*	**20%**	**Yes**	**Yes**
Urgent and After-Hours Care *Urgent Care and After-Hours settings*	**20%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Outpatient Hospital*	**20%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**10%**	**Yes**	**Yes**
Abortion *Elective, Medically Necessary*			
Outpatient Surgery *Performed in an Outpatient Hospital*	**20%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**10%**	**Yes**	**Yes**
Inpatient Hospital per admission	**20%**	**Yes**	**Yes**
Bariatric Surgery	**Not Covered**	**N/A**	**N/A**
Temporomandibular Surgery (TMD/TMJ)			
Outpatient Surgery *Performed in an Outpatient Hospital*	**20%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**10%**	**Yes**	**Yes**
Inpatient Hospital per admission	**20%**	**Yes**	**Yes**

HOSPITAL / SURGERY SERVICES cont.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Gender Affirming Surgery *Covered upper and lower body gender affirming surgeries.*			
Outpatient Surgery *Performed in an Outpatient Hospital*	**20%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**10%**	**Yes**	**Yes**
Inpatient Hospital per admission	**20%**	**Yes**	**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.*			
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 milage 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*	**None**	**N/A**	**N/A**
Lodging Limits *Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure 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. Does not include meals, international travel, hotel movies, entertainment, or any other services not specifically listed.*	**$50 per night, $100 per night if accompanied by a companion**	**N/A**	**N/A**
Daily Expenses *Includes incidental expenses such as meals and does not include personal expenses.*	**Not Covered**	**N/A**	**N/A**
Benefit Lifetime Maximum	**None**	**N/A**	**N/A**

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**	**Subject to Deductible**	**Applies to OOP**
	HDHP 1500		
Routine Pre-Natal and Post-Partum Care			
Pre-natal and post-partum visits	**20%**	**Yes**	**Yes**
Hospital Inpatient Includes Planed Birthing Center if available			
Per admission (facility) Includes Well baby facility fees when billed with mother	**20%**	**Yes**	**Yes**
Well Newborn	**20%**	**Yes**	**Yes**

DIAGNOSTIC TESTS & PROCEDURES

Includes Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings: These services are treated the same as Lab and X-ray Services in this section.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
Diagnostic Lab	**20%**	**Yes**	**Yes**
Diagnostic X-ray	**20%**	**Yes**	**Yes**
Diagnostic Tests performed in the Office	**20%**	**Yes**	**Yes**
High Tech/Advanced Radiology – CT, MRI, Nuclear Medicine and PET	**20%**	**Yes**	**Yes**
Mammograms			
Preventive	**$0**	**No**	**No**
Diagnostic	**20%**	**Yes**	**Yes**

Note: If your first mammogram of the Plan Year is Diagnostic, it will be covered at $0, not subject to Deductible. Please refer to your SPD for more information.

FERTILITY SERVICES

Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT, IVF and Fertility Drugs. Services to rule out the underlying medical causes of Infertility are part of the medical benefit. Fertility drugs (see Pharmacy section) and ZIFT and IVF are not covered.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
Fertility Services	**Not Covered**	**N/A**	**N/A**

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
Mental Health – Inpatient and Residential Treatment			
Per admission	**20%**	**Yes**	**Yes**
Partial Hospitalization			
Per day	**20%**	**Yes**	**Yes**
Mental Health – Intensive Outpatient, *Includes all Services provided during the day*	**20%**	**Yes**	**Yes**
Mental Health – Outpatient/Office			
Individual Visit Cost Share	**20%**	**Yes**	**Yes**
Group Visit Cost Share	**20%**	**Yes**	**Yes**
Substance Use Disorder – Inpatient and Residential Treatment *Detox covered under medical benefits.*			
Per admission	**20%**	**Yes**	**Yes**
Substance Use Disorder – Partial Hospitalization			
Per day	**20%**	**Yes**	**Yes**
Substance Use Disorder – Intensive Outpatient, *Includes all Services provided during the day.*	**20%**	**Yes**	**Yes**
Substance Use Disorder – Outpatient/Office			
Individual Visit Cost Share	**20%**	**Yes**	**Yes**
Group Visit Cost Share	**20%**	**Yes**	**Yes**

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

For Rehabilitative and Habilitative Care (Includes: Therapies for Congenital Defects and Birth Abnormalities and Early Intervention Services Provided by Kaiser), Outpatient Cost Share for therapies is applied on a one Copayment per provider per day basis. Outpatient Cost Share for therapies is applied on a one Copay per provider per day basis.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
Physical Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**20%** *60 visits per Plan year* (Visits are combined between therapies)*	**Yes**	**Yes**
Occupational Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**20%** *60 visits per Plan year* (Visits are combined between therapies)*	**Yes**	**Yes**
Speech Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**20%** *60 visits per Plan year* (Visits are combined between therapies)*	**Yes**	**Yes**

* Visit limits apply to Members eligible for Early Intervention Services (EIS) after separate EIS visits are exhausted.

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).

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
Physical/Speech/Occupational Therapy Annual maximum *Combined with social, educational, nutritional, and other Services.*	**$0** *45 visits per Plan year*	**No**	**Yes**

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 1500		
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	**20%** **Unlimited**	**Yes**	**Yes**
Hospice			
Hospital Inpatient	**20%**	**Yes**	**Yes**
Home Based	**20%**	**Yes**	**Yes**
Respite Services – Home Based	**20%**	**Yes**	**Yes**
Respite Services – Hospital Inpatient	**20%**	**Yes**	**Yes**
Hospice Special Services Program	**20%**	**Yes**	**Yes**
Skilled Nursing Facility Per admission Day maximum	**20%** *100 days per Plan year*	**Yes**	**Yes**

OTHER SERVICES			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
	HDHP 1500		
Acupuncture *Self-referred*	**Not Covered**	**N/A**	**N/A**
Acupuncture *Medically referred for Nausea, Pain Management*	**Not Covered**	**N/A**	**N/A**
Chiropractic Care (Self referred Visits with a Network or Planed provider) Visit maximum	**20%** *25 visits per Plan year*	**Yes**	**Yes**
Massage Therapy	**Not Covered**	**N/A**	**N/A**
Accidental Injury to Teeth *Repair of sound and natural teeth directly related to an accidental injury.*	**Not Covered**	**N/A**	**N/A**
Autism *A diagnosis of Autism Spectrum Disorder (ASD) is required for benefits to apply toward the maximum benefit amount.* Applied Behavioral Analysis Physical/Occupational/Speech Therapy Visit maximum	 **20%** **20%** **None**	 **Yes** **Yes**	 **Yes** **Yes**
Durable Medical Equipment (DME) Colorado DME/P&O formulary applies Glucometers, Peak Flow Meters DME Base items in the office	 **20%** **20%** **$0**	 **Yes** **No** **Yes**	 **Yes** **Yes** **Yes**
Oxygen	**20%**	**Yes**	**Yes**
Prosthetics and Orthotics (P&O)	**20%**	**Yes**	**Yes**
Hearing Aids – (For age 18 and younger) *Initial and replacement hearing aids for minor children with a verified hearing loss.* Benefit Limits	**20%** *One hearing aid, per ear, every 60 months unless alterations to existing hearing aid cannot adequately meet the needs of the child*	**Yes**	**Yes**
Hearing Aids – Adults	**Not covered**	**N/A**	**N/A**
Medical Foods *Amino acid modified products*	**$0**	**Yes**	**Yes**
Vision Hardware – Frames and Eyeglass Lenses or Contact Lenses (For age 19 and older)	**Not covered**	**N/A**	**N/A**
Vision Hardware – Frames and Eyeglass Lenses or Contact Lenses (For age 18 and younger) *Includes fitting exam*	**Not covered**	**N/A**	**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**	**Subject to Plan Deductible**	**Applies to Plan OOP**
	HDHP 1500		
Office Visit *Primary care, Specialty, Mental Health/Chemical Dependency, Well Child prevention, Gyn and Allergy injection visits are covered. All other visits not covered.* Visit Maximum *(Procedures and labs are excluded)*	**20%** *5 visits per Plan year*	**Yes**	**Yes**
Diagnostic X-ray *(X-ray and Ultrasound only)* Visit Maximum *(X-ray and Ultrasound only)*	**20%** *5 visits per Plan year*	**Yes**	**Yes**

Physical, Occupational & Speech Therapies Visit Maximum	**20%** *5 combined physical, occupational and speech therapy visits per Plan year*	**Yes**	**Yes**
Prescription Drug	**50%**	**Yes**	**Yes**

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	Subject to Plan Deductible	Applies to Plan OOP
	HDHP 1500		
Generic	*$20 up to 30 days' supply, $40 31-60 days' supply, $60 61-90 days' supply*	**Yes**	**Yes**
Brand	*$40 up to 30 days' supply, $80 31-60 days' supply, $120 61-90 days' supply*	**Yes**	**Yes**
Non-Formulary Brand	*$60 up to 30 days' supply, $120 31-60 days' supply, $180 61-90 days' supply*	**Yes**	**Yes**
Specialty Rx *(Including self-administered injectables)*	*20% per fill, up to 30 days' supply*	**Yes**	**Yes**
Note: Certain medications may be limited to 30-day supply.			
Mail Order Drugs			
3 Tier Mail Order			
Generic	*$20 up to 30 days' supply and $40 from 31 up to 90 days' supply*	**Yes**	**Yes**
Brand	*$40 up to 30 days' supply and $80 from 31 up to 90 days' supply*	**Yes**	**Yes**
Non-Formulary Brand	*$60 up to 30 days' supply and $120 from 31 up to 90 days' supply*	**Yes**	**Yes**
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order.			
Blood Factors	**$0**	**Yes**	**Yes**
Diabetic Coverage *Some diabetic supplies may be covered under Durable Medical Equipment.*			
Oral medications and Insulin	**Pays under applicable tier**	**Yes**	**Yes**
Diabetic testing supplies *(meters, test strips)*	**20%**	**No**	**Yes**
Diabetic administration devices *(syringes)*	**20%**	**Yes**	**Yes**
Fertility Drug Coverage	**Not covered**	**N/A**	**N/A**
Sexual Dysfunction	**Not covered**	**N/A**	**N/A**
Weight Loss	**Not covered**	**N/A**	**N/A**
Supplemental Preventive Drugs *Includes drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis, and stroke*	***$0 up to 90 days' supply***	**No**	**No**
ACA Mandated Drugs* (See Preventive Services for more information)			
Contraceptive Devices *(diaphragms, cervical caps, etc.)* **and Contraceptive Drugs (***FDA-approved and prescribed by your doctor)*	**$0**	**No**	**No**
Emergency Contraception*	**$0**	**No**	**No**
Preventive Breast Cancer Drugs	**$0**	**No**	**No**
Smoking Cessation	**$0**	**No**	**No**
Statins *(Cholesterol Lowering Agents)*	**$0**	**No**	**No**
PrEP for HIV Prevention	**$0**	**No**	**No**

Benefit Type	You Pay and/or Maximums	Subject to Plan Deductible	Applies to Plan OOP
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**	**No**
Oral Fluoride	**$0**	**No**	**No**
Folic Acid	**$0**	**No**	**No**
Iron Supplements	**$0**	**No**	**No**
Female Contraceptives *(Spermicides, male and female condoms, emergency contraceptives and sponges)*	**$0**	**No**	**No**
Bowel Prep	**$0**	**No**	**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.			
Items or Injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.), office visit for administration will also apply.			

Denver Public Schools

Colorado Benefit Summary
KP Use only: Plan IDs: H0231, H0234
Effective Date: 07/01/2023
This is a summary of Benefits for your Kaiser Permanente High Deductible Health Plan (HDHP)

OVERALL PLAN FEATURES

	HDHP 3000	HDHP 3500
Plan Accumulation Type	Plan Year	Plan Year
Plan Deductible		
Individual	**$3,000**	**$3,500**
Family	**$6,000**	**$7,000**
Embedded Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.		
Plan Deductible Accumulates to Out-of-Pocket Maximum	**Yes**	**Yes**
4th Quarter Carry Over	**No**	**No**
Annual Out-of-Pocket Maximum		
Individual	**$4,000**	**$6,350**
Family	**$8,000**	**$12,700**
Embedded 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.		

Copays: One Copay 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 Preventive Services Listing, Screenings and Immunizations for a comprehensive list of Covered Services. Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings 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	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	HDHP 3500		
Wellness Exams – Adults (Including *Well Woman*)	**$0**	**$0**	**No**	**No**
Mammograms				
Preventive	**$0**	**$0**	**No**	**No**
Diagnostic	**30%**	**30%**	**Yes**	**Yes**
Note: If your first mammogram of the Plan Year is Diagnostic, it will be covered at $0, not subject to deductible. Please refer to your SPD for more information.				
Wellness Exams – Children	**$0**	**$0**	**No**	**No**
Preventive Screenings	**$0**	**$0**	**No**	**No**
Immunizations (Preventive) *Adults and Children.*	**$0**	**$0**	**No**	**No**
Health Education and Self-management	**$0**	**$0**	**No**	**No**

OUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, or 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 except Mental Health providers are considered to be Primary Care providers for the purposes of determining Participant cost share. **Note:** Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	HDHP 3500		
Office Visits *Including House Calls*				
Office Visit	30%	30%	Yes	Yes
Referred Hospital Clinic Visits				
Provider	30%	30%	Yes	Yes
Facility Clinic Charges	30%	30%	Yes	Yes
Telemedicine *Telephone, Video, or Chat/Online communications*	$0	$0	No	Yes
Allergy *Office Visit cost share may apply*				
Injection	30%	30%	Yes	Yes
Testing	30%	30%	Yes	Yes
Serum only	$0	$0	Yes	Yes
Biofeedback Services *Medical and Mental Health Services*	30%	30%	Yes	Yes
Cardiac Rehab	30%	30%	Yes	Yes
Chemotherapy Services	30%	30%	Yes	Yes
Provided during an Office Visit	30%	30%	Yes	Yes
Dialysis Services	30%	30%	Yes	Yes
Home Dialysis	$0	$0	Yes	Yes
Hearing Exam *Audiometry exam and medical exam*				
Audiologist	30%	30%	Yes	Yes
Otolaryngologist	30%	30%	Yes	Yes
Infusion Services *Requires skilled or medical administration. Office Visit cost share may apply.*				
Infusion	30%	30%	Yes	Yes
Home Infusion *Infusion materials, drugs, and supplies*	30%	30%	Yes	Yes
Injections and Immunizations *Non-routine Office Visit cost share may apply.*				
Injection	30%	30%	Yes	Yes
Travel immunizations *Office Visit cost share may apply*				
Injection	Not Covered	Not Covered	N/A	N/A
Male Sterilization				
Outpatient Surgery *Performed in an Outpatient Hospital*	30%	30%	Yes	Yes
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	20%	20%	Yes	Yes
Nutrition Visits				
Office Visit	30%	30%	Yes	Yes
Pulmonary Rehab	30%	30%	Yes	Yes
Limits	None	None		

OUTPATIENT SERVICES cont.				
Benefit Type	**You Pay and/or Maximums**	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Radiation Therapy	**30%**	**30%**	**Yes**	**Yes**
Respiratory Therapy	**30%**	**30%**	**Yes**	**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)	**30%**	**30%**	**Yes**	**Yes**
UV Light Therapy Box (for Home Use)	**30%**	**30%**	**Yes**	**Yes**
Vision Refraction Exam				
Office Visit	**30%**	**30%**	**Yes**	**Yes**
Note: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty				
HOSPITAL / SURGERY SERVICES				
Benefit Type	**You Pay and/or Maximums**	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
	HDHP 3000	**HDHP 3500**		
Inpatient Hospital *Includes room and board for semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Ancillary Services, and Supplies. Additional cost for private rooms is not covered unless Medically Necessary.*				
Per admission	**30%**	**30%**	**Yes**	**Yes**
Ambulance				
Emergency Ground and Air Ambulance	**30%**	**30%**	**Yes**	**Yes**
Scheduled Ground and Air Ambulance	**30%**	**30%**	**Yes**	**Yes**
Non-Network or Network Hospital to Network Hospital *(repatriation)*	**$0**	**$0**	**No**	**Yes**
Emergency Services *Accident and Illness. High tech radiology procedure Cost Share is applied in addition to ED Cost Share*	**30%**	**30%**	**Yes**	**Yes**
Urgent and After-Hours Care *Urgent Care and After-Hours settings*	**30%**	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**20%**	**20%**	**Yes**	**Yes**
Abortion *Elective, Medically Necessary*				
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**20%**	**20%**	**Yes**	**Yes**
Inpatient Hospital per admission	**30%**	**30%**	**Yes**	**Yes**
Bariatric Surgery	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Temporomandibular Surgery (TMD/TMJ)				
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**20%**	**20%**	**Yes**	**Yes**
Inpatient Hospital per admission	**30%**	**30%**	**Yes**	**Yes**

HOSPITAL / SURGERY SERVICES cont.				
Benefit Type	**You Pay and/or Maximums**	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Gender Affirming Surgery *Covered upper and lower body gender affirming surgeries.*				
Outpatient Surgery *Performed in an Outpatient Hospital*	**30%**	**30%**	**Yes**	**Yes**
Outpatient Surgery *Performed in an Ambulatory Surgical Center*	**20%**	**20%**	**Yes**	**Yes**
Inpatient Hospital per admission	**30%**	**30%**	**Yes**	**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.*				
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 milage 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*	**None**	**None**	**N/A**	**N/A**
Lodging Limits *Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure 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. Does not include meals, international travel, hotel movies, entertainment, or any other services not specifically listed.*	**$50 per night, $100 per night if accompanied by a companion**	**$50 per night, $100 per night if accompanied by a companion**	**N/A**	**N/A**
Daily Expenses *Includes incidental expenses such as meals and does not include personal expenses.*	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Benefit Lifetime Maximum	**None**	**None**	**N/A**	**N/A**

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**	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
	HDHP 3000	**HDHP 3500**		
Routine Pre-Natal and Post-Partum Care				
Pre-natal and post-partum visits	**30%**	**30%**	**Yes**	**Yes**
Hospital Inpatient Includes Planed Birthing Center if available				
Per admission (facility) Includes Well baby facility fees when billed with mother	**30%**	**30%**	**Yes**	**Yes**
Well Newborn	**30%**	**30%**	**Yes**	**Yes**

DIAGNOSTIC TESTS & PROCEDURES

Includes Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings: These services are treated the same as Lab and X-ray Services in this section.

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	**HDHP 3500**		
Diagnostic Lab	**30%**	**30%**	**Yes**	**Yes**
Diagnostic X-ray	**30%**	**30%**	**Yes**	**Yes**
Diagnostic Tests performed in the Office	**30%**	**30%**	**Yes**	**Yes**
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine and PET	**30%**	**30%**	**Yes**	**Yes**
Mammograms				
Preventive	**$0**	**$0**	**No**	**No**
Diagnostic	**30%**	**30%**	**Yes**	**Yes**

Note: If your first mammogram of the Plan Year is Diagnostic, it will be covered at $0, not subject to deductible. Please refer to your SPD for more information.

FERTILITY SERVICES

Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT, IVF and Fertility Drugs. Services to rule out the underlying medical causes of Infertility are part of the medical benefit. Fertility drugs (see Pharmacy section) and ZIFT and IVF are not covered.

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	**HDHP 3500**		
Fertility Services	**Not Covered**	**Not Covered**	**N/A**	**N/A**

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	**HDHP 3500**		
Mental Health – Inpatient and Residential Treatment				
Per admission	**30%**	**30%**	**Yes**	**Yes**
Partial Hospitalization				
Per day	**30%**	**30%**	**Yes**	**Yes**
Mental Health – Intensive Outpatient, *Includes all Services provided during the day*	**30%**	**30%**	**Yes**	**Yes**
Mental Health – Outpatient/Office				
Individual Visit Cost Share	**30%**	**30%**	**Yes**	**Yes**
Group Visit Cost Share	**30%**	**30%**	**Yes**	**Yes**
Substance Use Disorder – Inpatient and Residential Treatment *Detox covered under medical benefits.*				
Per admission	**30%**	**30%**	**Yes**	**Yes**
Substance Use Disorder – Partial Hospitalization				
Per day	**30%**	**30%**	**Yes**	**Yes**
Substance Use Disorder – Intensive Outpatient, *Includes all Services provided during the day.*	**30%**	**30%**	**Yes**	**Yes**
Substance Use Disorder – Outpatient/Office				
Individual Visit Cost Share	**30%**	**30%**	**Yes**	**Yes**
Group Visit Cost Share	**30%**	**30%**	**Yes**	**Yes**

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

For Rehabilitative and Habilitative Care (Includes: Therapies for Congenital Defects and Birth Abnormalities and Early Intervention Services Provided by Kaiser), Outpatient Cost Share for therapies is applied on a one Copayment per provider per day basis. Outpatient Cost Share for therapies is applied on a one Copay per provider per day basis.

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	**HDHP 3500**		
Physical Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**30%** *60 visits per Plan year* (Visits are combined between therapies)*	**30%** *60 visits per Plan year* (Visits are combined between therapies)*	**Yes**	**Yes**
Occupational Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**30%** *60 visits per Plan year* (Visits are combined between therapies)*	**30%** *60 visits per Plan year* (Visits are combined between therapies)*	**Yes**	**Yes**
Speech Therapy Visit maximum *Visit limits do not apply for the treatment of autism*	**30%** *60 visits per Plan year* (Visits are combined between therapies)*	**30%** *60 visits per Plan year* (Visits are combined between therapies)*	**Yes**	**Yes**

* Visit limits apply to Members eligible for Early Intervention Services (EIS) after separate EIS visits are exhausted.

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).

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	**HDHP 3500**		
Physical/Speech/Occupational Therapy Annual maximum *Combined with social, educational, nutritional, and other Services.*	**$0** *45 visits per Plan year*	**$0** *45 visits per Plan year*	**No**	**Yes**

SKILLED CARE

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
	HDHP 3000	**HDHP 3500**		
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	**30%** **Unlimited**	**30%** **Unlimited**	**Yes**	**Yes**
Hospice				
Hospital Inpatient	**30%**	**30%**	**Yes**	**Yes**
Home Based	**30%**	**30%**	**Yes**	**Yes**
Respite Services – Home Based	**30%**	**30%**	**Yes**	**Yes**
Respite Services – Hospital Inpatient	**30%**	**30%**	**Yes**	**Yes**
Hospice Special Services Program	**30%**	**30%**	**Yes**	**Yes**
Skilled Nursing Facility Per admission Day maximum	**30%** *100 days per Plan year*	**30%** *100 days per Plan year*	**Yes**	**Yes**

OTHER SERVICES				
Benefit Type	**You Pay and/or Maximums**	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
	HDHP 3000	**HDHP 3500**		
Acupuncture *Self-referred*	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Acupuncture *Medically referred for Nausea, Pain Management*	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Chiropractic Care (Self referred Visits with a Network or Planed provider)	**30%**	**30%**	**Yes**	**Yes**
Visit maximum	*25 visits per Plan year*	*25 visits per Plan year*		
Massage Therapy	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Accidental Injury to Teeth *Repair of sound and natural teeth directly related to an accidental injury.*	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Autism *A diagnosis of Autism Spectrum Disorder (ASD) is required for benefits to apply toward the maximum benefit amount.*				
Applied Behavioral Analysis	**30%**	**30%**	**Yes**	**Yes**
Physical/Occupational/Speech Therapy	**30%**	**30%**	**Yes**	**Yes**
Visit maximum	**None**	**None**		
Durable Medical Equipment (DME)				
Colorado DME/P&O formulary applies	**30%**	**30%**	**Yes**	**Yes**
Glucometers, Peak Flow Meters	**30%**	**30%**	**No**	**Yes**
DME Base items in the office	**$0**	**$0**	**Yes**	**Yes**
Oxygen	**30%**	**30%**	**Yes**	**Yes**
Prosthetics and Orthotics (P&O)	**20%**	**20%**	**Yes**	**Yes**
Hearing Aids – (For age 18 and younger) *Initial and replacement hearing aids for minor children with a verified hearing loss.*	**30%**	**30%**	**Yes**	**Yes**
Benefit Limits	*One hearing aid, per ear, every 60 months unless alterations to existing hearing aid cannot adequately meet the needs of the child*	*One hearing aid, per ear, every 60 months unless alterations to existing hearing aid cannot adequately meet the needs of the child*		
Hearing Aids – Adults	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Medical Foods *Amino acid modified products*	**$0**	**$0**	**Yes**	**Yes**
Vision Hardware – Frames and Eyeglass Lenses or Contact Lenses (For age 19 and older)	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Vision Hardware – Frames and Eyeglass Lenses or Contact Lenses (For age 18 and younger) *Includes fitting exam*	**Not Covered**	**Not Covered**	**N/A**	**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	You Pay and/or Maximums	Subject to Plan Deductible	Applies to Plan OOP
	HDHP 3000	**HDHP 3500**		
Office Visit *Primary care, Specialty, Mental Health/Chemical Dependency, Well Child prevention, Gyn and Allergy injection visits are covered. All other visits not covered.* Visit Maximum *(Procedures and labs are excluded)*	**30%** *5 visits per Plan year*	**30%** *5 visits per Plan year*	**Yes**	**Yes**
Diagnostic X-ray *(X-ray and Ultrasound only)* Visit Maximum *(X-ray and Ultrasound only)*	**20%** *5 visits per Plan year*	**20%** *5 visits per Plan year*	**Yes**	**Yes**
Physical, Occupational & Speech Therapies Visit Maximum	**30%** *5 combined physical, occupational and speech therapy visits per Plan year*	**30%** *5 combined physical, occupational and speech therapy visits per Plan year*	**Yes**	**Yes**
Prescription Drug	**50%**	**50%**	**Yes**	**Yes**

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	You Pay and/or Maximums	Subject to Plan Deductible	Applies to Plan OOP
	HDHP 3000	**HDHP 3500**		
Generic	*$20 up to 30 days' supply,* *$40 31-60 days' supply,* *$60 61-90 days' supply*	*$20 up to 30 days' supply,* *$40 31-60 days' supply,* *$60 61-90 days' supply*	**Yes**	**Yes**
Brand	*$40 up to 30 days' supply,* *$80 31-60 days' supply,* *$120 61-90 days' supply*	*$40 up to 30 days' supply,* *$80 31-60 days' supply,* *$120 61-90 days' supply*	**Yes**	**Yes**
Non-Formulary Brand	*$60 up to 30 days' supply,* *$120 31-60 days' supply,* *$180 61-90 days' supply*	*$60 up to 30 days' supply,* *$120 31-60 days' supply,* *$180 61-90 days' supply*	**Yes**	**Yes**
Specialty Rx *(Including self-administered injectables)*	*20% per fill,* *up to 30 days' supply*	*20% per fill,* *up to 30 days' supply*	**Yes**	**Yes**
Note: Certain medications may be limited to 30-day supply.				
Mail Order Drugs				
3 Tier Mail Order				
Generic	*$20 up to 30 days' supply and $40 from 31 up to 90 days' supply*	*$20 up to 30 days' supply and $40 from 31 up to 90 days' supply*	**Yes**	**Yes**
Brand	*$40 up to 30 days' supply and $80 from 31 up to 90 days' supply*	*$40 up to 30 days' supply and $80 from 31 up to 90 days' supply*	**Yes**	**Yes**
Non-Formulary Brand	*$60 up to 30 days' supply and $120 from 31 up to 90 days' supply*	*$60 up to 30 days' supply and $120 from 31 up to 90 days' supply*	**Yes**	**Yes**
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order.	*$60 up to 30 days' supply and $120 from 31 up to 90 days' supply*	*$0 up to 90 days' supply*		
Blood Factors	**$0**	**$0**	**Yes**	**Yes**

OUTPATIENT PRESCRIPTION DRUGS cont.

Benefit Type	You Pay and/or Maximums	You Pay and/or Maximums	Subject to Plan Deductible	Applies to Plan OOP
Diabetic Coverage *Some diabetic supplies may be covered under Durable Medical Equipment.*				
Oral medications and Insulin	***Pays under applicable tier***	***Pays under applicable tier***	**Yes**	**Yes**
Diabetic testing supplies *(meters, test strips)*	**30%**	**30%**	**No**	**Yes**
Diabetic administration devices *(syringes)*	**30%**	**30%**	**Yes**	**Yes**
Fertility Drug Coverage	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Sexual Dysfunction	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Weight Loss	**Not Covered**	**Not Covered**	**N/A**	**N/A**
Supplemental Preventive Drugs *Includes drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis, and stroke*	***$0 up to 90 days' supply***	***$0 up to 90 days' supply***	**No**	**No**
ACA Mandated Drugs* *(See Preventive Services for more information)*				
Contraceptive Devices *(diaphragms, cervical caps, etc.)* **and Contraceptive Drugs** (FDA-approved and prescribed by your doctor)	**$0**	**$0**	**No**	**No**
Emergency Contraception*	**$0**	**$0**	**No**	**No**
Preventive Breast Cancer Drugs	**$0**	**$0**	**No**	**No**
Smoking Cessation	**$0**	**$0**	**No**	**No**
Statins *(Cholesterol Lowering Agents)*	**$0**	**$0**	**No**	**No**
PrEP for HIV Prevention	**$0**	**$0**	**No**	**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**	**$0**	**No**	**No**
Oral Fluoride	**$0**	**$0**	**No**	**No**
Folic Acid	**$0**	**$0**	**No**	**No**
Iron Supplements	**$0**	**$0**	**No**	**No**
Female Contraceptives *(Spermicides, male and female condoms, emergency contraceptives and sponges)*	**$0**	**$0**	**No**	**No**
Bowel Prep	**$0**	**$0**	**No**	**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.

Items or Injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.), office visit for administration will also apply.

Definitions

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

The following terms, when capitalized and used in any part of this Benefit 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 of whether a participant or beneficiary is entitled to a reasonable alternative standard for reward under a wellness program.
- 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: The Kaiser Permanente Insurance Company (KPIC) 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.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accord with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or because of, the discharge or transfer.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985.

Coinsurance: A percentage of Eligible Charges that you must pay for certain Covered Services as described in the "Schedule of Benefits" section.

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

Copayment: (aka Copay) A specified dollar amount that you must pay for certain Covered Services as described in the "Schedule of Benefits" section.

Cost Sharing/Share: Copayments, Coinsurance and Deductibles.

Covered Service: Services that meet the requirements described in this Benefit 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 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: A specific dollar amount you are required to pay for certain types of Covered Services annually, before benefits will be paid. The Deductible is calculated after the Eligible charges are determined and prior to any Coinsurance or Copayment.

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 is the basis for eligibility. This Benefit Booklet sometimes refers to a Dependent or Participant as "You." Third generation dependents or dependents of a dependent are covered for the first 31 days of life.

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

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

Eligible Charges Network Providers:

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

Eligible Charges Non-Network Providers:

- For Emergency Services and scheduled services at a Network Hospital or ambulatory surgical center rendered by Non-Network Providers, the plan's Qualifying Payment Amount (QPA) – which is the median contracted rate (the middle amount in an ascending or descending list of contracted rates), adjusted for market consumer price index in urban areas (CPIU). The Cost Share will be based on the Recognized Amount (RA) which is lower of the QPA or the provider billed charges for a given service. The QPA is based on contracted rates for the same or similar insurance market (individual, large group, small group, self-insured employer); geography, based on MSAs (Metropolitan Statistical Area - a geographical region with a relatively high population density at its core and close economic ties throughout the area) and the non-MSA areas in a state; and service provided in the same or similar specialty or type of facility. The contracted rates must reflect the total provider reimbursement amount contractually agreed, including cost-sharing, whether it's under a direct or indirect contract with the plan.

- To determine the QPA when there is no contracted rate KPIC will use the lower of an underlying fee schedule or the derived amount from Kaiser claims history.

- In the alternative KPIC may attempt to contract with the provider on a patient-by-patient basis

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

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

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

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

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, 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;
    - (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). The notice must include: (i) that the provider or facility is Non-Network with respect to the Plan; (ii) a good faith estimated amount that the provider or facility may charge including a notification that the provision of the estimate or the consent to be treated does not constitute a contract with respect to those estimated charges; (iii) a list of any Network providers at the facility who are able to furnish the items and services involved and you may be referred, at your option, to that provider; and (iv) information about whether prior authorization or other care management limitations may be required in advance of receiving the items or services at the facility.

  Note: Once your condition is stabilized, covered Services that You receive are Post Stabilization Care and not Emergency Services EXCEPT when You receive Emergency Services from Non-Network Providers AND federal law requires coverage of Your Post-Stabilization Care as Emergency Services. Post-Stabilization Care is subject to all of the terms and conditions of this SPD including but not limited to Prior Authorization requirements unless federal law applies and defines such Post-Stabilization Care as Emergency Services

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) of 1986.

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:

- 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.

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

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

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

Material Modification: A material modification includes:

- Any coverage modification that alone or combined with other changes made at the same time would be considered by "an average participant" to be "an important change in covered benefits or other terms of coverage under the plan or policy."
- An enhancement of covered benefits, services or other more general, plan or policy terms. For example, coverage of previously excluded benefits or reduced cost-sharing.
- A "material reduction in covered services or benefits" or more strict requirements for "receipt of benefits," including:
    - Changes or modifications that reduce or eliminate benefits
    - Increases in cost-sharing
    - Imposing a new referral requirement

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 age 65 and older, 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 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 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 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 annually. This amount includes Cost Sharing and Deductible amounts.

Participant: A person who is enrolled in the Plan if that person is eligible in his own right and not because if his or her relationship to someone else. This Benefit 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 plan sponsor named in the "Legal and Administrative Information" section.

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

Post Stabilization Care: 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 Care is covered only when (1) it is 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: Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice Services.

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

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

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

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

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.

Service(s): Healthcare, including mental health care and behavioral health treatment to treat pervasive developmental disorders or autism**,** services and items.

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

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

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

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.

Surprise Billing: Unexpected 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 Network cost-sharing amount. Your Cost-Sharing amount is calculated based upon the 'Recognized Amount' for a Non-Network provider/facility, and for Emergency Services and Ancillary Services, the Recognized Amount is the All Payer Model Agreement amount, if applicable, or the amount calculated pursuant to a specified state law if applicable, or the Qualifying Payment Amount (QPA).

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

Eligibility, Enrollment, and Effective Date

Plan eligibility requirements

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

Service Area eligibility requirement

The Participant must live or work in a Kaiser Service Area at the time of enrollment. The Service Area cities are listed in the back of this Benefit Booklet. You cannot enroll or continue enrollment as a Participant or Dependent if you cease to live or work within the cities listed.

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.

Additional eligibility requirements

You are eligible to enroll and continue enrollment as a Participant if you are:

- An active full-time employee (20 hours per week)

As an enrolled Participant you may enroll the following Dependents:

- Your Spouse
- Your or your Spouse's children (including adopted children, children placed with you for adoption or under legal guardianship. Other dependent persons (but not including foster children) which you or your Spouse is the child's court-appointed guardian (or was when the person reached age 18) who are under age 26. Note: State income taxes may apply for coverage provided to dependents, for whom you are not the primary source of financial support. Contact your Human Resources department for more information.
- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled dependent if they meet all the following requirements:
    - they are incapable of self-sustaining employment because of a physically- or mentally disabling injury, illness or condition that occurred prior to reaching the age limit for Dependents;
    - they receive 50 percent or more of their support and maintenance from you or your Spouse; and
    - You provide proof of their incapacity and dependency within 60 days of request (see "Disabled dependent certification" below in this "Additional eligibility requirements" section).

Disabled dependent certification

A dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as a disabled dependent. You must provide documentation of your dependent's incapacity and dependency as follows:

- If your Dependent is enrolled, you will be sent a notice of his or her loss of eligibility a due to reaching the age limit. Your Dependent's eligibility will terminate as described in the notice unless you provide documentation of his or her incapacity and dependency and he or she is determined to be eligible as a disabled dependent. If your Dependent does not meet the eligibility requirements as a disabled dependent, you will be notified that he or she is not eligible and the eligibility termination date. If your Dependent is determined to be eligible as a disabled dependent, there will be no lapse in coverage.
- If your dependent is not enrolled and you are requesting enrollment, you must provide documentation of his or her incapacity and dependency. If your dependent is determined to be eligible as a disabled dependent, documentation of his or her incapacity and dependency will be requested annually.

Persons barred from enrolling

You cannot enroll if you have had your eligibility terminated for cause.

Participants with Medicare and retirees

If, during your enrollment in this Plan, you are or become eligible for Medicare (please see "Medicare" in the "Definitions" section for the meaning of "eligible for" Medicare) or you retire, your enrollment options are as follows:

- If federal law requires that the Plan is primary and Medicare coverage is secondary, your coverage under this Plan will be the same as it would be if you had not become eligible for Medicare.
- If you are or become eligible for Medicare and are in a class of beneficiaries for which the Plan is secondary to Medicare, contact the Plan Sponsor to determine your enrollment options.

Medicare late enrollment penalty

If you become eligible for Medicare Part B and do not enroll during the initial Medicare enrollment period, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. Also, if you go 63 days or longer without Medicare Part D coverage or creditable prescription drug coverage, you may have to pay a late enrollment penalty when you enroll in a Medicare Part D plan. Creditable prescription drug coverage means prescription drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage. If you are or become eligible for Medicare Part D, your Plan Sponsor is responsible for informing you about whether your drug coverage under this Plan

is Medicare Part D creditable prescription drug coverage at the times required by CMS and upon your request.

When You Can Enroll and When Coverage Begins

Your Plan Sponsor will inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Plan eligibility requirements" in this "Eligibility, Enrollment, and Effective Date" section, enrollment is permitted as described below and coverage begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Plan Sponsor may have additional requirements, which allows enrollment in other situations.

New employees

When your Plan Sponsor informs you that you are eligible to enroll, you may enroll yourself and any eligible Dependents.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is the first of the month following date of hire. Dependent children are covered to age 26. Employees are required to work at least 20 hours per week.

Adding new Dependents to an existing account

To enroll a new Dependent such as a new Spouse, a newborn child, or a newly adopted child, contact your Plan Sponsor.

New Dependent effective date of coverage

Other than a newborn or a newly adopted child (including a child placed with you for adoption), the effective date of coverage for newly acquired Dependents is the first of the month following the date the qualifying change is received by your Plan Sponsor. For a newborn or a newly adopted child, the effective date of coverage is as follows:

- A new Spouse is covered from date of marriage if enrolled within 30 days of marriage.
- A newborn child is covered from the moment of birth if you enroll the child within 31 days after birth.
- A newborn is covered from birth; if the newborn child is not enrolled within 31 days, the newborn is covered only for the first 31 days of life. Pharmacy Services provided prior to enrollment require prepayment and claim submission for reimbursement.
- A newly adopted child (including a child placed with you for adoption) will begin on the date when the adopting parent gains the legal right to control the child's health care if you enroll the child within 31 days of that date.

Open enrollment

You may enroll as a Participant (along with any eligible Dependents), and existing Participants may add eligible Dependents, during the Plan's open enrollment period. Your Plan Sponsor will let you know when the open enrollment period begins and ends and the effective dates of coverage.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- **Special enrollment of a Family due to new Dependents.** You may enroll as a Participant with your Dependents within 30 days after marriage, birth, adoption, or placement for adoption by submitting to your Plan a Health Plan–approved enrollment application. You must enroll at least one newly acquired Dependent when you enroll as a Participant.

  The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Plan receives an enrollment application from the Participant. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

- **Special enrollment due to loss of other coverage**. You may enroll as a Participant (along with any eligible Dependents), and existing Participants may add eligible Dependents, by contacting your Plan Sponsor within 30 days after loss of other coverage, if all of the following are true:
  - The Participant or at least one of the Dependents had other coverage when he or she previously declined Plan coverage
  - The loss of the other coverage is due to one of the following:
    - exhaustion of COBRA coverage;
    - loss of eligibility or termination of employer contributions for non-COBRA coverage (but not termination for cause or for nonpayment of an individual non-group plan);
    - loss of eligibility for "no share of cost" Medi-Cal or Healthy Families Program coverage (but not termination for cause); or
    - reaching a lifetime maximum on all benefits.

  Note: If you are enrolling yourself as a Participant along with at least one eligible Dependent, only one of you must meet the requirements stated above.

  The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Plan

receives an enrollment or change of enrollment application from the Participant.

- **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.

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

- **Special enrollment due to reemployment after military service.** If you terminated your health care coverage because you were called to active duty in the military service, you may be able to be reenrolled in the Plan if required by federal law. Please ask your Plan Sponsor for more information.

- **Special enrollment due to a Section 125 qualifying event.** If your Plan is a Section 125 cafeteria plan, you may enroll along with any eligible Dependents and existing Participants may add eligible Dependents, if you experience an event that your Plan designates as a special enrollment qualifying event.

Special Enrollment Rights

If you waive medical coverage under the Plan and you subsequently lose your other coverage for any reason, you and your eligible Dependents may enroll in the Plan within 30 days of losing other coverage. In addition, if you have new Dependents as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your new Dependent(s) within 30 days of the qualifying event.

In addition, if you waive medical coverage under the Plan for yourself and/or your dependents because you are enrolled in Medicaid or your state's Children's Health Insurance Program (CHIP formerly known as SCHIP), you will be permitted to enroll in the Plan when:

- You or your dependent's Medicaid or CHIP coverage is terminated because of loss of eligibility, providing you request special enrollment within 60 days of the loss of coverage.

- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, providing you request special enrollment within 60 days of when eligibility is determined.

How to Obtain Services

As a Participant or Dependent, you must receive all Covered Services from Network Providers inside the Service Area, 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.

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

Routine Care

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

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number (see the "Customer Service Phone Numbers" section 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.

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

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 personal 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 Plan 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 Specialists in optometry, psychiatry, substance use disorders
- Obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology
- Network chiropractic services

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

Additionally, some regions allow self-referral to certain specialties:

Colorado Region

- Denver/Boulder Service Area
  You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente except for the anesthesia clinical pain department, laboratory, and radiology and for specialty procedures such as a CT scan, MRI, colonoscopy or surgery.
- Northern and Southern Colorado Service Areas
  You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals in the Provider Directory www.kp.org, click *Find a Doctor.*

Prior Authorizations

Certain Services 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 in order 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.

Required Prior-Authorization List

- 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: 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.

Second Opinions

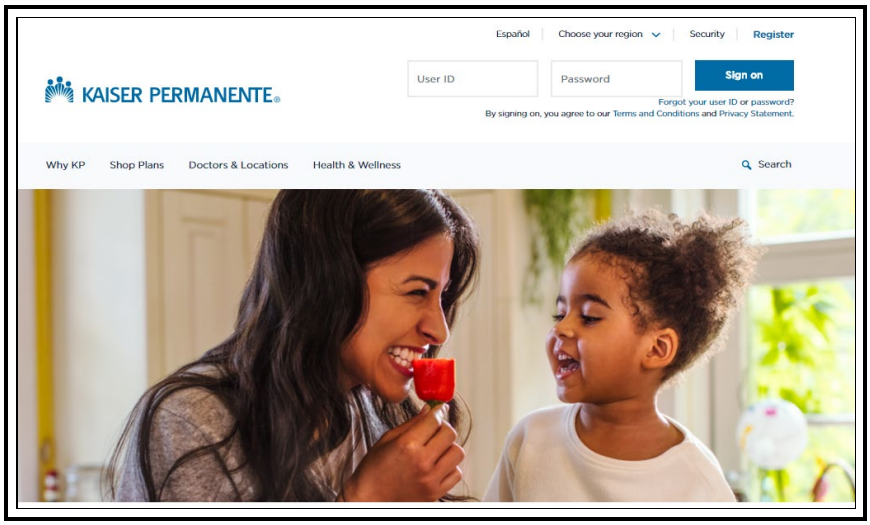
Upon request and subject to payment of any applicable Cost Share, you may obtain a second opinion from:

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

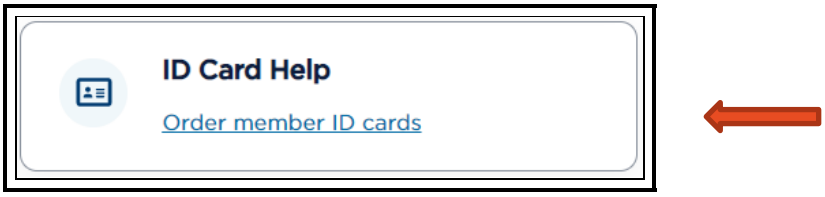
Your Identification Card

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 www.kp.org, 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.

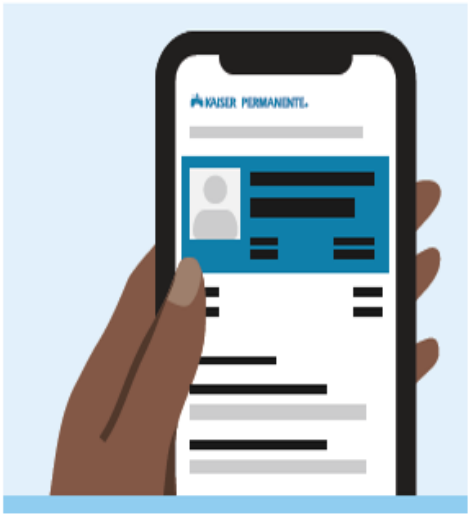
Download a Digital ID Card

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 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 Kaiser Permanente Service Area, and you do not work within a Kaiser Permanente Service Area, you will be required to change your health plan to one that serves your area. Please contact your employer for instruction.

Getting Assistance

Kaiser Permanente wants you to be satisfied with the health care you receive. If you have any questions or concerns about the care you are receiving, please discuss them with your personal Network Physician or with any other Network Providers who are treating you. They want to help you with your questions. You may also call customer service at the number listed in the "Customer Service Phone Numbers" section.

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 Numbers" 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, 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 www.kp.org for Emergency Department locations in Your area).

- Same-day appointments are available at many locations (please refer to www.kp.org 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 www.kp.org for locations in your area).
- Additionally, Kaiser Permanente care is available at certain Target Clinics in Southern California https://kptargetclinic.org.

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, post-stabilization, and out of area Urgent Care from non–Network Providers. The Non–Network Provider care discussed in this section is not covered unless it meets both 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 Care that are part of the same visit for Emergency Services is covered if authorized by Kaiser Permanente or until your attending emergency physician determines you are able to travel (using non-medical/non-emergency medical transportation), there is a Network facility within a "reasonable" distance considering your medical condition and you have access to/can pay for the non-medical transportation.

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 from Network Providers or Non-Network Providers anywhere in the world, (subject to the "General Exclusions, General Limitations, Coordination of Benefits, and Reductions" 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 have been admitted to a Non-Network hospital, your stay will be covered if Kaiser Permanente is notified within 24 hours or as soon as reasonably possible after stabilization of your condition.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your attending physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care 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 Durable Medical Equipment (DME), External Prosthetics and Orthotics. Post-

Stabilization Care 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; you have access to/can pay for the non-medical transportation;

Note: You will be responsible for any Post Stabilization Services you consent to pay. For example, if 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 in order to coordinate care.

To request Prior Authorization to receive Post-Stabilization Care from a Non–Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as reasonably possible). A Kaiser Permanente representative will then discuss your condition with the Non–Network Provider. If Kaiser Permanente decides that you require Post-Stabilization Care and that this care would be covered if you received it from a Network Provider, they will authorize your care from the Non–Network Provider or arrange to have a Network Provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a Network Hospital, Network Skilled Nursing Facility, or designated Non–Network Provider provide your care, they may authorize special transportation services that are medically required to get you to the provider. If this occurs, then those special transportation services will be covered, even if they would not be covered under "Ambulance Services" in the "Benefits and Cost Sharing" section if a Network Provider had provided them.

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

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

Denials of Appeals of claims for Emergency Services and related Post Stabilization Services are subject to the External Appeal process located in the Claims and Appeals Section.

Urgent Care

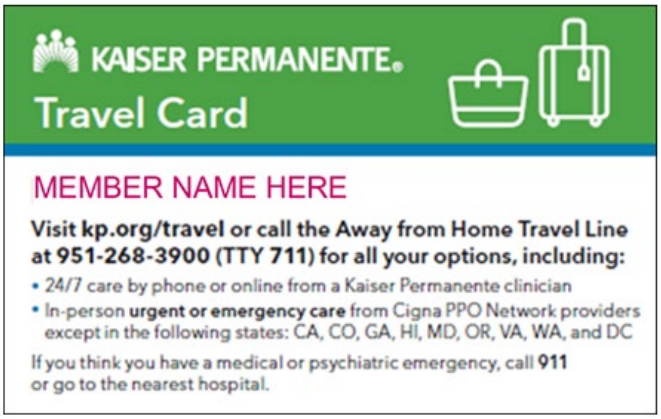
Within the Service Area

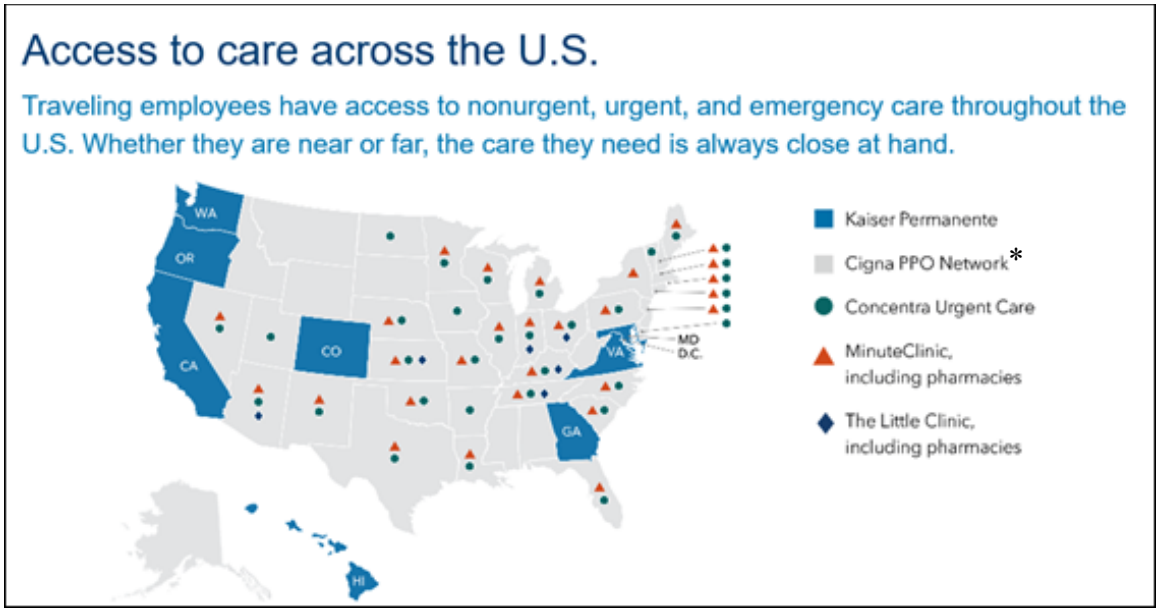
You may need urgent care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you are in the Service Area and think you may need urgent care, call the urgent care or advice nurse telephone number (see "Customer Service Phone Numbers" or sign on to the members.kp.org website).

The following Services are not covered under this section:

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





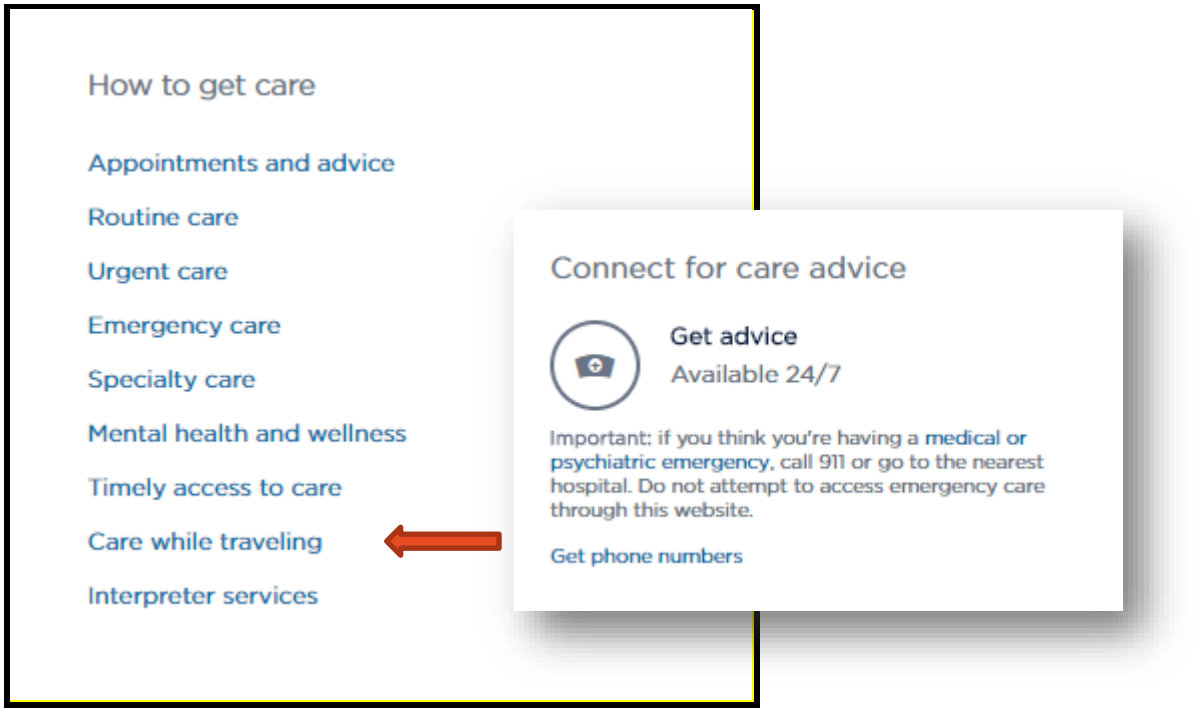
- For **Nonurgent** care you can always schedule in-person visits in states with Kaiser Permanente facilities or use kp.org or the Kaiser Permanente app across the U.S. to get 24/7 care and advice from Kaiser Permanente clinicians by phone or online.
- You may also seek **Urgent** care at The Little Clinics (TLC) MinuteClinic®, Concentra, or any other urgent care facility outside a state where Kaiser Permanente operates. If you get care at MinuteClinic®, Cigna, 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.
- *Cigna PPO network is only available if your employer has opted in and is not available to members in WA and the NW

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

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, 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, Post-Stabilization Care, 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 "Schedule of Benefits" 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 were given Prior Authorization for inpatient Post-Stabilization Care 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.

Benefits and Cost Sharing

The only Services that are covered under this Plan are those that this "Benefits and Cost Sharing" section says that are covered, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the "General Exclusions, 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, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" 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

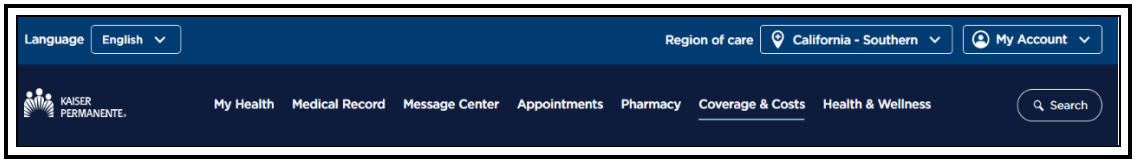
A Kaiser Permanente health professional will determine if services are Medically Necessary for each member.

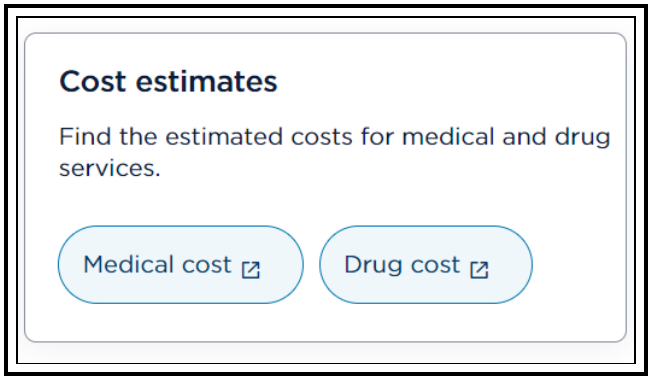
Cost Sharing (Copayments and Coinsurance)

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. Coinsurance is a calculated percentage of the provider Allowable Amount.

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 "Schedule of Benefits" describes Benefit, visit or quantity limits applicable to certain Covered Services. If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.

Plan Year Deductible

DEPO, HDHP 3000 & HDHP 3500 Plans Generally you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The Annual Deductible Amounts are listed in the "Schedule of Benefits".

HDHP 1500 Plan Generally you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The Annual Deductible amount is listed in the "Schedule of Benefits"

- The services subject to the deductible 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.

Plan Year Out-Of-Pocket Maximums

There are limits to the total amount of Cost Sharing you must pay annually in a Plan Year for certain Covered Services that you receive in the same Plan Year. Those limits can be found in the "Schedule of Benefits."

DEPO, HDHP 3000 & HDHP 3500 Plans If you are part of a Family that includes two people (counting the Participant and any Dependents), you reach the Plan Year out-of-pocket maximum when you meet the maximum per Participant or Dependent, or when your Family meets the maximum for a Family (whichever happens first).

HDHP 1500 Plan If you have other family members in this plan, the overall family out-of-pocket maximum limit must be met.

After you reach the annual 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.

Outpatient Services

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

- Primary Care office visits including nutrition visits with Registered Dieticians (R.D.), State licensed nutritionists, and Certified Diabetic Educators (C.D.E)
- Specialty Care office visits, including consultation and second opinions
- Allergy Services
- Ambulance
- 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 tests, and other diagnostic tests such as EEGs EKGs performed during an office visit
- Dialysis Services
- Drugs that require administration or observation by medical personnel
- Durable Medical Equipment
- Habilitative and Rehabilitative Services
- Health Education
- Hearing Exam and Hearing Aids /Services for those 18 and under.
- 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 medical treatment of temporomandibular joint (TMJ) dysfunction - Dental treatment of TMJ dysfunction is not covered
- Maternity - prenatal and postnatal visits
- Outpatient surgery including FDA approved internally implanted Prosthetic devices such as breast implants following a covered mastectomy (applicable Cost Share is waived if admitted when both services occur in the same facility) (the inpatient coinsurance applies for outpatient surgeries resulting in an admission to the same facility)
- Physical, Occupational & 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 procedures performed in the office
- Ultraviolet light treatments
- Vision Refraction

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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
- 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 medical 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

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. 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: Kaiser Centers for Complementary Medicine 1-844-800-0788 or www.kpccm.org.

Exclusions:
The following services are not covered:

- Chiropractic services for conditions other than Neuromusculoskeletal Disorders
- Behavior training and sleep therapy

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

Clinical Trials

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

"Qualified Individual" means an enrollee who is eligible to participate in an Approved Clinical Trial 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 though 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. Exception services required prior to transplant.
- 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 our 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 use of any equipment and obtain items from a Network Provider. Coverage is limited to the standard item of equipment 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 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, 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
- Contact lenses following cataract surgery and glasses. 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:

- 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 are limited to correcting underlying medical conditions causing infertility. Services to rule out the underlying medical causes of Infertility are part of the medical benefit

Exclusions:

- Donor semen or eggs, and Services related to their procurement and storage, including long term cryopreservation
- Advanced reproductive technologies such as in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT) and variations of these procedures
- Services to reverse voluntary, surgically induced fertility (for example, because of a vasectomy or tubal ligation)
- Any experimental, investigational or unproven procedures or therapies
- Artificial Insemination
- Fertility services when infertility is caused by or related to voluntary sterilization

Hearing Aids for Children up to age 18

The following Services are covered up to the benefit maximum listed in the "Schedule of Benefits":

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

You do not need to purchase aids for both ears at the same time. The maximum benefit amount for each Hearing Aid must be used at the initial point of sale. The 60-month period begins at the initial point of sale for each ear and is tracked separately for each ear. Any unused portion of the Allowance at the point of sale may not be used later. Two Hearing Aids are covered only when both are required to provide significant improvement that is not achievable with only one Hearing Aid as determined by a Network Provider.

Exclusions:

- Hearing Aids prescribed or ordered prior to enrollment or after termination of coverage
- Coverage for any Hearing Aid if payment has been made for an aid for the same ear in the previous 60 months
- 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 (see surgical implants under Durable Medical Equipment and Prosthetics)

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 by 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
- Durable Medical Equipment and Medical supplies
- Palliative 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 or Participant Spouse's newborn child is automatically covered under the Participant's membership for the first 31 days after birth. Well newborn (as defined by hospital billing), charges billed as part of the mother's bill will be attributed to the mother's Cost Share requirements. Separately billed well newborns may be subject to his/her own Cost Share and deductible, check the "Schedule of Benefits" section. Eligible sick newborns are subject to all Plan provisions including his/her own Cost Share requirements. If the parent of the newborn child is a Dependent child of the Participant, the newborn is **not** eligible for benefits unless enrolled as a dependent of the Participant.

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.

* Charges for well newborns (as defined by the hospital), billed as part of the mother's bill will be attributed to the mother's Cost Share requirements. Charges billed separately for Eligible sick and well newborns (as defined by the hospital) are subject to all Plan provisions including his/her own Cost Share requirements.

Medical Foods

Medical 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. Medical foods are not foods that are generally available in retail grocery stores. Medical 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

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 of 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** the 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**
   - The **first refill of a 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;
        - Smoking Cessation products; or
    - 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; or
    - 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 pharmacy criteria are met. To request a formulary exception contact Customer Service. Prescriptions written by dentists are not eligible for non-formulary exceptions.

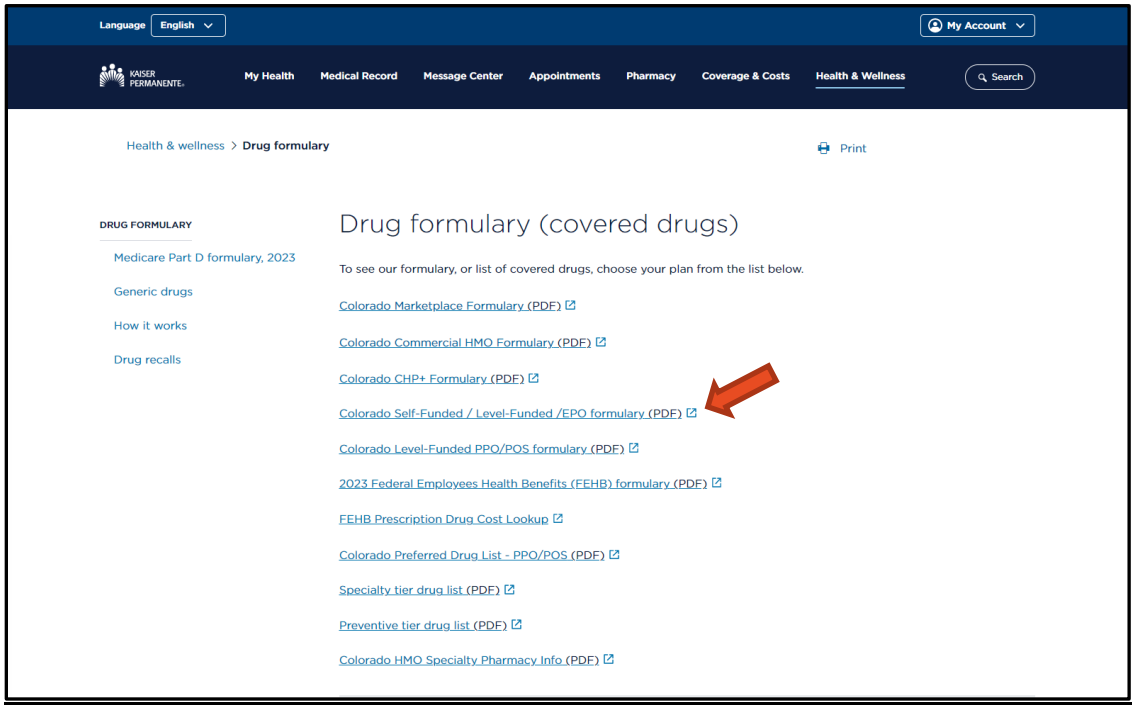
The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the formulary includes a pre-determined amount of an item that constitutes a Medically Necessary day's supply. The pharmacy may reduce the day supply dispensed 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.

Mail Order Service, subject to any Limitations, Copayments and Deductibles, 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, view the formulary, learn more about mail order or print a claim form, sign on to www.kp.org click on *Pharmacy* or call OptumRx at 1-866-427-7701.



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

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.

The 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.

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 Services 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: www.healthcare.gov/center/regulations/prevention.html.

- Recommendations in effect for less than one year and contraceptive Services (for Religious Employers or Eligible Organizations) may not be applicable to your plan.
- Preventive Services will be applied based on the member's medical status regardless of stated gender.

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
- Immunizations administered strictly for the purpose of travel outside of the United States (exception: COVID-19 immunizations)

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; or
- 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 for communication training, educational training or vocational training;
- Therapy primarily indicated for vocational training or re-training purposes, including sports physical therapy; or
- 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)

Early Intervention Services Not Provided by Kaiser Permanente (Colorado only benefit)

A. **Definition**

1. In 2007, 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: 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 and that meet all the following criteria:
  - **The treatment is referred by KPIC and administered by a Network Provider. Reminder certain services require Prior Authorization:**

    Required Prior-Authorization List
    - 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.
  - 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.

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, whether or not you have dyslexia;
- Educational testing;
- Teaching skills for employment or vocational purposes;
- Professional growth courses; and
- Training for a specific job or employment counseling.

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.

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 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; and
- Blood, blood products and their administration.

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.

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
- Reasonable transportation and lodging expenses inside and outside of the Service Area when approved in advance by Kaiser Permanente. Includes transportation, meals and lodging for the patient plus one other person.
- Voice therapy lessons

Gender Affirming Surgery Limitations and Exclusions

- Reversal of genital surgery or surgery to revise secondary sex characteristics
- **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 such as Vaniqa);
- 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

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.

Limitations and 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 afterhours 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).

Exclusion:
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.

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

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

Acupuncture
Bariatric Surgery
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 - Dental Services and dental X-rays, including dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate for newborn Participants when prescribed by a Network Provider, unless the Participant is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Network Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma and, unless otherwise specified herein, (a) and (b) are received at a Plan Hospital, Plan Facility or Skilled Nursing Facility.
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, in consultation with Medical Group, 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 and drugs. The following services related to the further diagnosis and treatment of Infertility after initial diagnosis has been made:
- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Fertility Services when the infertility is caused by or related to voluntary sterilization;
- Donor semen or eggs, and Services related to their procurement and storage, including cryopreservation;
- 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 Vaniqa
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.
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.
Hearing Aid Services - Hearing Aids, hearing devices and related or routine examinations and Services for adults (age 19 and over).
Hypnotherapy (Hypnosis)
Immunizations - administered strictly for the purpose of travel outside of the United States, with the exception of vaccinations associated with COVID-19.
Illegal services Treatments, procedures, equipment, drugs, devices, supplies or any other plan benefits, in each case, that are illegal under applicable law.
Licensed Provider Charges for a Provider acting outside the scope of his license.
Massage Therapy - except when provided as part of other covered Services.
Medical supplies - Disposable supplies for home use.
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.
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.
Nutritional supplements and formulas - except for formula needed for the treatment of inborn errors of metabolism.
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.
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 Weight Control Drugs used in the treatment of Fertility Drugs used in the treatment of Sexual Dysfunction
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.
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
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 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 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.
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 - Medical benefits for low vision aids, eyeglasses, contact lenses and follow-up care thereof, except that Covered Services and expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows cataract surgery or loss of lens due to eye disease for aphakia or aniridia.
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 Cost Sharing, 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 on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans. However, if the provider has contracted with the Secondary Coverage Plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Coverage Plan to determine its benefits.
- The amount a benefit is reduced by the Primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a calendar 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 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 a husband or wife is covered under This Coverage Plan as an employee and as a Dependent (if the Plan's eligibility rules allow this), the benefits for the Dependent will be coordinated as if they were provided under another Coverage Plan. This means the Coverage Plan of the person as an Employee will pay first.

7. 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 Plan reduces its Benefits as described below for 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:

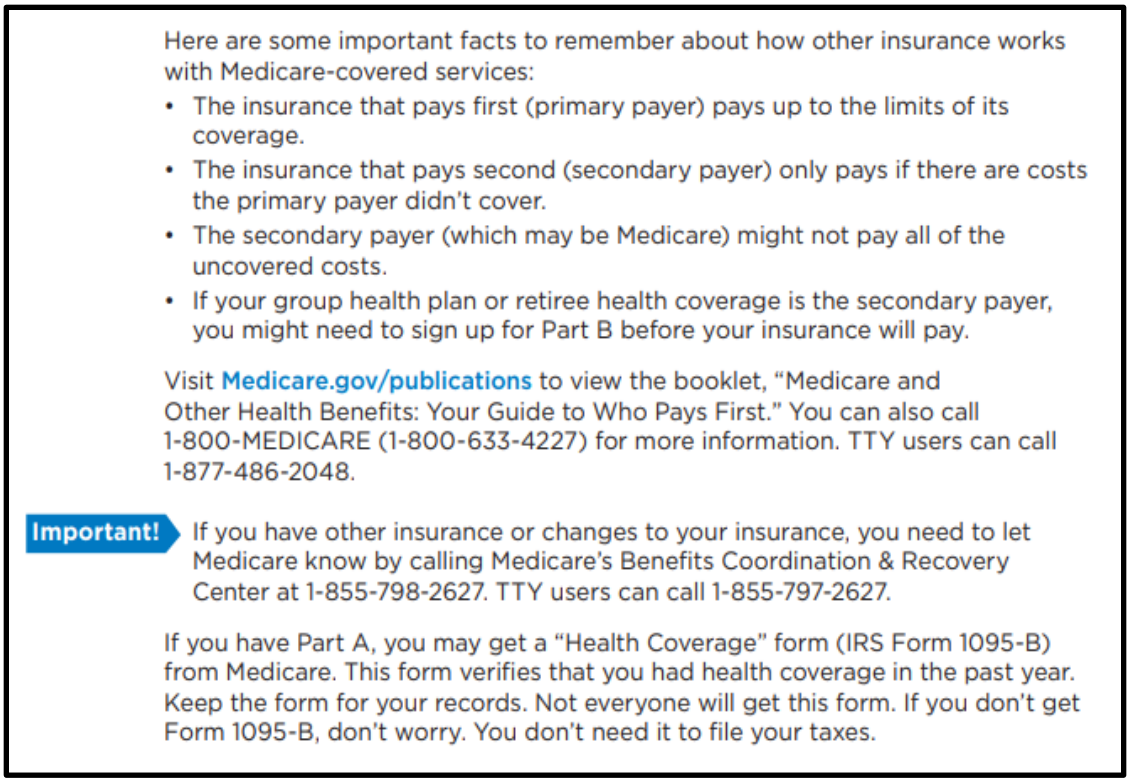
- The person is eligible for, but not enrolled in, Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B. To determine when Medicare is primary see the excerpt from https://www.medicare.gov/publications/10050-Medicare-and-You.pdf below:

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 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 Plan 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 Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits the Plan 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 Plan 100% of any benefits you receive 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 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 T\the Plan alleges some or all of those funds are due and owed to the Plan, 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, 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 a 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 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 Plan, 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 Plan 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:

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

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 Plan 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 Cost Sharing for these Services; you will be credited any such payments toward the amount you must reimburse the Plan 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, the Plan 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 the Plan's lien will not exceed the total amount of your obligation to the Plan under the preceding paragraph.

Within 30 days after entering a Surrogacy Arrangement, you must send written notice of the arrangement, 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
- Any other information the Plan may request to satisfy its rights to:

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

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

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

You may appoint an authorized representative to help you file your grievance. A written authorization must be received from you before any information will be communicated to your representative.

Kaiser Permanente is committed to providing quality care and a timely response to your concerns. You can discuss your concerns with our representatives at most Network Facilities, or you can call Customer Services at the number on your 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
- through www.kp.org

You will receive a confirmation letter within five days after receipt of your grievance. You will receive a written decision within 30 days after receipt of 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, or at www.kp.org, and a Customer Services representative notifies you orally about our decision, you will not receive a confirmation letter.

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 a 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 will 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 will be made 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, or a claim that your attending provider determines is urgent.

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, a Concurrent Care 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	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. If the claim is not complete, KPIC will notify you as soon as possible, but not later than 24 hours of receipt of the claim. You will have 48 hours to provide the information necessary to complete the claim. A decision will be made not later than 48 hours after the administrator receives the requested information, or within 48 hours after the expiration of the 48-hour deadline for submitting additional information, whichever is earlier.	If the claim when initially filed is proper and complete, a decision will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of KPIC. You will be notified within the initial 15 days if an extension will be needed. The notice will state the reason for the extension. A decision will be made not later than 15 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information, or within 15 days after the expiration of the 45-day deadline for submitting additional information, which-ever is earlier.	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 KPIC's control. You will be notified within the initial 30 days if an extension will be needed. The notice will state the reason for the extension. A decision will be made not later than 30 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 30-day period and will 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.

* 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 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, 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.

How to File a Claim
Network Providers are responsible for submitting claims for their services on your behalf and will be paid directly by KPIC 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 you to direct that benefit payment on your behalf be paid directly to the provider (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 (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 Plan should pay for them. Include a copy of the bill and any supporting documents. Your claim form (or letter) and the related documents constitutes your claim.

Your claim must include all the following information:

- Patient name, address, and Kaiser Permanente 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 the Kaiser Permanente Web site at www.kp.org**,** log in, and go to *Coverage and Costs,* then select *Submit a Claim*.

If KPIC pays a Post-Service Claim, it will pay you directly, except that it will pay the provider if your claim includes a written request to pay your benefits directly to the provider (assignment of benefits) or before the claim is processed, a written notice is received indicating you have assigned your right to payment to the provider.

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 Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of services or supplies except to the extent the Plan actually chooses to do so.

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 ID card or in the “Customer Service Phone Numbers” section.

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 explain:

- 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;
- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon

in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request;
- The notice will also state how and when to request a review of the denied claim,
- If applicable, the notice will also contain a statement of your right to bring a civil action of an adverse benefit determination following completion of all levels of review; and
- 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 the written request to the Plan at:

For **Pre-Service and Concurrent Care Denials** 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: 1-800-788-0710

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 Fax 1-206-630-1859 Phone 1-866-458-5479
Cigna, Providers Pre-Service Appeals	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	**Cigna Behavioral UM Appeals** Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone call:

Oral Appeal	Cigna Providers Pre-Service Appeals
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

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 Public Health Service Act (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 www.kp.org (Log into My Health Manager, select Manage My Plan & Coverage, then click on Claims Summary list of the State Assistance Programs under the Resources banner) or https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting.

Deemed Exhaustion

If the Plan does not adhere to the 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.

The Plan 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 will not afford deference to the initial claim denial and will be conducted by the Claims Fiduciary (named in the “Legal and Administrative Information” section), 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 will 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 will not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (or 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.

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion

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, Plan will provide you with written notice of its decision. If the Plan determines that benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

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

- The reasons for the denial, including references to the 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.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) include 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 information about those procedures.
- The notice will also include a statement of your right to bring an action following an adverse benefit determination following completion of all levels of review.

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 the written request to the Plan at:

For **Pre-Service and Concurrent Care Denials** 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: 888-987-2252 Phone: 1-800-788-0710
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 Fax 1-206-630-1859 Phone 1-866-458-5479
Cigna Providers- Pre-Service Appeals	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	**Cigna Behavioral UM Appeals** Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone call**:**

Oral Appeal	Cigna Providers Pre-Service Appeals
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

Timing of Final Appeal Determinations

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

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

* 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, the Plan will provide you with written notice of its decision. If the Plan determines that benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice will 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) include 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.
- The notice will also include a statement of your right to bring an action following an adverse benefit determination following completion of all levels of review.

Next Steps

If after exhausting the appeals process, you are still not satisfied, your remaining remedies include the right to sue in and voluntary dispute resolution options, such as mediation or independent External Review as described below.

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 denials, complete the External Review request form on www.kp.org and send the written request to:

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: 1-800-788-0710
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: Appeals Coordinator Phone: 1-866-458-5479 Fax: 1-206-630-1859
Cigna Providers- Pre- Service Appeals	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	**Cigna Behavioral UM Appeals** Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone call:

Oral Appeal	Cigna Providers Pre-Service Appeals
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

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 URAC (Utilization Review Accreditation Commission**)** 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 will not be eligible for any financial incentives based on the likelihood that the IRO will support a 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 many submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, 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 decide to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making its decision, the IRO will notify the claimant and KPIC of that decision.

(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 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 (if applicable), the treatment code and its corresponding meaning (if applicable), 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 documentation, considered, 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 Federal (or possibly state) 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 review 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 as directed by the IRO.

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 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, the 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 requires the IRO to provide notice of the final external review decision, in accordance with the requirements set forth 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.

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.

Termination

Termination Due to Loss of Eligibility

If you lose eligibility for the Plan, your participation terminates on the last day of the month.

You may be eligible for COBRA, see the "Continuation of Coverage" section below.

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 the safety of the Administrator or Provider personnel or any person or property at a Network Facility.
(2) Commit theft from the Administrator or Network Provider or at a Network Facility.
(3) Performs an act that constitutes fraud or makes 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 an ID 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, including the right to convert to non-group coverage.

Continuation of Coverage

COBRA Continuation Coverage

This summary contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This summary generally explains COBRA continuation coverage, when it may become available to you and your Dependents, if any, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your eligibility for coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan's COBRA Administrator.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this "COBRA Continuation Coverage" section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Participants and Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualifying Events

If you are a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- The Participant dies
- The Participant's hours of employment are reduced
- The Participant's employment ends for any reason other than his or her gross misconduct
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse, the Participant

If you are the Dependent (other than a spouse) of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- The parent-Participant dies
- The parent-Participant's hours of employment are reduced
- The parent-Participant's employment ends for any reason other than his or her gross misconduct
- The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both)
- The parents become divorced or legally separated
- You lose eligibility under the Plan as a Dependent

If you are a retiree entitled to coverage under the Plan, sometimes you may become a qualified beneficiary if the following qualifying event occurs:

- A proceeding in bankruptcy under title 11 of the United States Code. If the proceeding in bankruptcy is filed with respect to the Plan Sponsor, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree will become a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if the bankruptcy results in their loss of coverage under the Plan.

Election of COBRA Coverage and Notice of Qualifying Event
The Plan will offer qualified beneficiaries the opportunity to elect COBRA continuation coverage only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the termination of the Participant's employment (except when it is for gross negligence) or a reduction of hours of Participant's employment, the death of the Participant, commencement of a proceeding in bankruptcy with respect to the Plan Sponsor, or the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Sponsor must notify the Plan's COBRA Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the Participant and his or her spouse or a Dependent's loss of eligibility under the Plan as a Dependent), the Participant must notify the Plan's COBRA Administrator within 60 days after the qualifying event occurs. You must provide this notice to the COBRA Administrator, check with you employer for notice requirements.

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Duration of COBRA Coverage
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, the Participant's becoming

entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation of the Participant and his or her spouse, or a Dependent's loss of eligibility under the Plan as a Dependent, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of the Participant's employment or reduction of the Participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, when the qualifying event is the end of the Participant's employment or reduction of the Participant's hours of employment, AND the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiary's other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension of COBRA Continuation Coverage
There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

First, if the Participant or his or her Dependents covered under the Plan is determined by the Social Security Administration to be disabled and the Plan's COBRA Administrator is notified in a timely manner, the Participant and all his or her Dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Check with your employer for any requirements regarding notice and documentation of any required information pertaining to disability, and the time period for giving this notice.

Second, if another qualifying event (as explained later in this paragraph) occurs while receiving 18 months of COBRA continuation coverage, then the spouse and Dependent children may qualify for up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is transmitted to the Plan. This extension may be available to the spouse and other Dependents receiving COBRA continuation coverage if the Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child loses eligibility under the Plan as a Dependent child.

This extension of COBRA continuation coverage can occur only if the event would have caused the Spouse or other Dependent to lose coverage under the Plan had the first qualifying event not occurred.

In order to protect your rights, you should keep the Plan Administrator informed of any changes in your address. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Questions relating to the Plan or your right to COBRA continuation coverage should be address to the Plan's COBRA Administrator. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

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 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"). The Plan 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 the Plan Administrator.

Legal and Administrative Information

The following is the plan name, identification number, and fiscal records information of the Plan.

Plan Name:	Denver Public Schools
Year Begins	July 1
Year Ends:	June 30
Type of Plan:	Self-funded Medical Benefit Plan
Claims Administrator:	Kaiser Permanente Insurance Company
Claims Fiduciary:	Harrington Health
Plan Administrator:	Edwin Hudson 1860 Lincoln Street 9th Floor Denver, CO 80203
Funding Medium:	Self-funded; paid from general assets
Contributing Source:	Employer and Employee
Service of Legal Process:	Edwin Hudson, Chief of Talent 1860 Lincoln Street 9th Floor Denver, CO 80203

Employers/Sponsors Offering Benefits

Denver Public Schools
1860 Lincoln Street 11th Floor
Denver, CO 80203

Service Areas

Participants must live or work 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 your zip code visit https://individual-family.kaiserpermanente.org/healthinsurance

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, BOULDERELDORADO 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, KIMMBALL
LARAMIE	PINEBLUFFS
LARIMER	BELLVUE, 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

Customer Service Phone Numbers

General Customer Service

Colorado Region	877-883-6698

Utilization Management for Out-of-Network Emergency Services

Colorado Region	303-338-3800

Advice Nurses

Colorado Region	866-311-4464

Interpreter Services

Colorado Region	877-883-6698

TTY

All regions	771 or 877-870-0283

Pharmacy Benefit Information

All Regions	866-427-7701

Claims Administrator:

KPIC Self-Funded Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547
Payor ID # 94320

Pharmacy Claim Form

Instructions for Submitting Form

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
3. Send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, P.O. Box 29044, Hot Springs, AR 71903**

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy Receipts for Reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- ○ Date prescription filled
- ○ Name and address of pharmacy
- ○ Prescribing physician name or ID number
- ○ National Drug Code (NDC) number
- ○ Name of drug and strength
- ○ Prescription number (Rx number)
- ○ Quantity

Section B – Pharmacy Information *(for compound prescriptions ONLY)*

(Pharmacist must complete and sign)

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

* Individual quantities must equal the total quantity.
† Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		
Total		

X _____
Signature of Pharmacist

Section C – Coordination of Benefits

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare: If you have not already done so, submit the claim to the Primary Plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

When submitting a copay receipt: If your Primary Plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

***Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

***California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ORX5262-KPI_161208

Medical Claim Form

Medical Claim Form

Self-Funded Plan

KAISER PERMANENTE®

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM. PLEASE PRINT IN INK.
Please submit one claim form per patient. All questions must be answered for prompt processing. Attach itemized bills from your provider. **Note: See your Plan documents for applicable claims filing requirements.**

SEND THIS COMPLETED CLAIM FORM TO: KAISER PERMANENTE INSURANCE COMPANY (KPIC)
SELF-FUNDED CLAIMS ADMINISTRATOR
P.O. BOX 30547
SALT LAKE CITY, UT 84130-0547
CUSTOMER SERVICE NUMBER: 1-866-213-3062

Note: This form only needs to be completed if the provider is not submitting a claim on your behalf or you are requesting reimbursement for out of pocket expenses.

PARTICIPANT DATA

NAME OF PLAN	PLAN ID	WORK PHONE ( )	HOME PHONE ( )
PARTICIPANT NAME LAST FIRST MIDDLE		SOCIAL SECURITY NUMBER	MEDICAL RECORD #
HOME ADDRESS STREET	CITY	STATE	ZIP-CODE
MARITAL STATUS __ Single Married Divorced Widowed Separated	OTHER COVERAGE? __ Yes No If Yes, complete section below		

PATIENT DATA

PATIENT NAME LAST FIRST MIDDLE		SEX __Male__ Female	PHONE NUMBER
DATE OF BIRTH	AGE	DISABLED DEPENDENT Yes No	

RELATIONSHIP TO EMPLOYEE ☐Spouse ☐Domestic Partner ☐Son ☐Daughter ☐Other (Describe)_____

If this patient is a dependent child, is he/she a full time college student? ☐Yes ☐No If yes, name of school:_____

Were these charges incurred as a result of an on-the-job illness or injury? ☐Yes ☐No Other accident ☐Yes ☐No
If the claim is the result of any kind of accident or injury, complete the following information: Date:_____Time:_____
Description of what happened:_____

OTHER COVERAGE DATA – PLEASE READ INSTRUCTIONS ON BACK

IS THIS PATIENT EMPLOYED? __ Yes __ No	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER

IS THIS PATIENT OR ANY OTHER FAMILY MEMBER COVERED BY OTHER HEALTHCOVERAGE OR PLAN? Yes No Complete Section

Name of Insured or Participant	Name/Address of Insurance Company or Plan	ID Number	Group Number

IS THE PATIENT COVERED BY MEDICARE? ☐Yes ☐No

AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE: I hereby authorize KPIC, its third party administrators, my Plan, and any health care provider that provided services in connection with this claim to disclose to KPIC, its third party administrators, and any other source of coverage for those services, medical records and information pertaining to the services and patient identified in this claim, for the purpose of adjudication and payment of the claim. I understand that treatment, payment, enrollment, eligibility for benefits may not be conditioned on my providing or refusing to provide this authorization. This authorization is effective immediately and shall remain in effect for one year, unless a different date is specified here_____. This authorization may be revoked by the patient at any time, effective upon receipt, except to the extent that a disclosing party or others have acted in reliance upon this authorization. I understand that the recipient of information may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. A copy of this authorization is as valid as the original. The patient has a right to a copy of this authorization.

PATIENT/PARTICIPANT SIGNATURE: (Parent or guardian, if minor) DATE:

PROVIDER INFORMATION (OPTIONAL)

HAS UTILIZATION MANAGEMENT BEEN CONTACTED FOR PRECERTIFICATION? ☐Yes ☐No If yes, Authorization Number:_____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE ITEMS 1, 2, 3 OR 4 TO THE DIAGNOSIS CODE BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE
1. _____ 2. _____ 3. _____ 4. _____

DATE(S) OF SERVICE		PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS/ MODIFIER	DIAGNOSIS CODE	FULL DESCRIPTION OF PROCEDURE/SERVICE	DAYS/ UNITS	CHARGE AMOUNT
FROM	THROUGH						
MO | DY | YR	MO | DY | YR						
| |	| |						
| |	| |						
| |	| |						

PROVIDER FEDERAL TAX I.D. NUMBER __SSN __EIN	PATIENT'S ACCT NUMBER	TOTAL CHARGES $	AMT PAID $	BALANCE DUE $

NAME, SIGNATURE, CREDENTIALS OF TREATING PHYSICIAN/SUPPLIER	PROVIDER BILLING NAME, ADDRESS, ZIP CODE AND PHONE#
PRINTED NAME:_____CREDENTIALS____ SIGNED:_____DATE:_____	

HOW TO FILE YOUR CLAIM

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, OR OMITTING A MATERIAL FACT, MAY BE SUBJECT TO CIVIL OR CRIMINAL PROSECUTION AND PENALTIES.

This form is designed to help you file a claim for health care services received by you or an enrolled family member. If a doctor, hospital or other healthcare provider has already filed a claim directly with KPIC on your behalf, please do not submit a Member Medical Claim Form for the same services. Please see your Plan documents for applicable claim filing requirements.

1. Complete the Participant Data and Patient Data sections of the claim form.
2. See instructions below regarding the Other Coverage Data section.
3. Complete and sign the Authorization section.
4. Either have the provider complete the Provider Information section, or attach itemized bills provided by the provider. Each bill/receipt must include:
   - The name of the patient
   - Date expenses were incurred
   - Nature of encounter (i.e. office visit, x-ray, etc.)
   - Any other information your Plan requires.
5. For reimbursement of any out-of-pocket expenses you incurred, you must include a copy of a receipt from the provider, and evidence of your payment to the provider, such as a credit card receipt.
6. Send the completed claim form, itemized bills and attachments to:

   KAISER PERMANENTE INSURANCE COMPANY (KPIC)
   SELF-FUNDED CLAIMS ADMINISTRATOR
   P.O. BOX 30547
   SALT LAKE CITY, UT 84130-0547

Note: Please be aware that if the provider holds a contract to provide services for your Plan, payment of a claim will always be made to the provider, even if you paid the provider directly. In that circumstance, you will need to seek reimbursement from the provider.

INSTRUCTIONS FOR OTHER COVERAGE

If the patient has coverage under any other plan, in addition to the Plan administered by KPIC, you may be able to receive benefits under both plans. This may happen if both spouses or domestic partners (where applicable) work and both carry family coverage through their respective employers or have other coverage. If you filed a claim with the other coverage, you will need to submit the explanation of benefits or other communication from the other coverage showing their adjudication of the claim, in addition to this Claim Form and copies of itemized bills and receipts.

VERSION 5.2
LAST REVISION 9/11/08
CEL

Non-Discrimination Notice

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. We also:

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

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

If you need these services, call: 1-866-213-3062 for TTY 711
If you believe that KPIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the KPIC Civil Rights Coordinator, 3701 Boardman-Canfield Rd, Canfield, OH 44406 telephone number 1-866-213-3062. You can file a grievance by mail or phone. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Consumer Assistance Tools

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your benefits, or you are required to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ክፍያ በቋንቋዎ እርዳታ የማግኘት መብት አለዎ። ስለ ጥቅማጥቅሞችዎ ጥያቄዎች ካሉዎት፣ ወይም በተወሰነ ቀን እንዲያከናውኑ የሚጠበቅዎ ድርጊት ካለ፣ ስቴትዎ ወይም ክልልዎ ከተርጓሚ ጋር እንዲነጋገር በተሰጠዎ ስልክ ቁጥር ይደውሉ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن المزايا الخاصة بك أو قد طُلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր նպաստների, կամ Դուք պարտադրված եք գործողություններ ձեռնարկել մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsɔ̀ɔ̀ - wùdù (Bassa): Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké gbo-kpá-kpá dyé dɛ́ m̀ mìɔùn nìin bídí-wùdù mú pídyi. Ɔ jŭ ké m̀ dyi dyi-diè-dɛ̀ ɓě ɓédɛ́ bá kpáná ɓě m̀ kɔ̃ m̀ ké dyéɛ jè dyí, mɔɔ ɔ jŭ ké wa dyi níin m̀ mɛ nyu dɛ dɛ́ɛ́ ɓě ɓó wé jɛ̀ɛ́ dɔ̀ kɔ̃ɛɛ ní, nìí, m̀ mɛ dá nɔ̀ɓà ɓɛ́ wa tòà ɓó nì ɓódɔ́ɔ mɔɔ ɓó nì gbɛ̃ɛ̀ɔ̀ bìɛ, ɓɛ́ m̀ ké nyɔ-wudúún-zà-nyɔ̀ dɔ̀ gbo wùdù.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার সুবিধাগুলির সম্পর্কে আপনার যদি কোন প্রশ্ন থাকে, অথবা একটি নির্ধারিত দিনের মধ্যে যদি আপনার কোন পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সঙ্গে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

Northern California Region	1-800-663-1771
Southern California Region	1-800-533-1833
Colorado Region	1-877-883-6698
Mid-Atlantic States Region	1-877-740-4117
Northwest Region	1-866-800-3402
Georgia Region	1-866-800-1486
TTY	711

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan. • Kaiser Permanente Insurance Company (KPIC), Ordway Building, One Kaiser Plaza, Oakland, CA 94612

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Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo benepisyo o may mga butang nga nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的福利有任何疑問，或者您被要求在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chuukese): Mei wor omw pwuung omw kopwe neuneu aninis non kapasen fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw pekin insurance, are ika a men auchea omw kopwe fori pwan ekoch fofor mei namot ngeni omw plan, ke tongeni kori ewe nampa ren omw state ika neni (asan) pwe eman chon awewe epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de vos avantages ou si vous devez prendre des mesure à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Leistungsanspruchs haben oder Sie bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઇ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને તમારા લાભો વિશે પ્રશ્નો હોય, અથવા કોઈ ચોક્કસ તારીખથી તમને પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પુરો પાડવામાં આવેલ નબંર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

ʻōlelo Hawaiʻi (Hawaiian): He pono a ua loaʻa no kekahi kōkua me kāu ʻōlelo inā makemake a he manuahi no hoʻi. Inā he mau nīnau kāu e pili ana i kāu pono keu i ka polokalamu ola kino, a i ʻole inā ke haʻi nei iāʻoe e hana koke aku i kēia ma mua o kekahi lā i waiho ʻia, e kelepona aku i ka helu i loaʻa nei no kāu mokuʻāina a i ʻole panaʻāina no ka walaʻau ʻana me kekahi kanaka unuhi ʻōlelo.

हिन्दी (Hindi): आपको बिना कोई कीमत चुकाए आपकी भाषा में मदद पाने का अधिकार है। यदि आप आपके लाभ के बारे में कोई सवाल पूछना चाहते हैं या आपको किसी निश्चित तारीख तक कोई कारवाई करने की आवश्यकता है,तो आप आपके राज्य या क्षेत्र के लिए दिये गए नंबर पर फोन करके किसी दुभाषिए से बात करें।

Hmoob (Hmong): Koj muaj cai tau txais kev pab txhais ua koj hom lus pub dawb. Yog koj muaj lus nug txog koj cov txiaj ntsig, lossis koj yuav tsum tau ua raws li hnub hais tseg ntawd, hu rau tus nab npawb xovtooj ntawm lub xeev lossis hauv ib cheeb tsam uas tau muab rau koj mus tham nrog ib tug kws txhais lus.

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara elele gị, ma ọ bụ na achọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị i ji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda dda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep kadagiti benepisioyo wenno, mangkalikagum kadakayo a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

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Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente.In caso di domande riguardanti le tue agevolazioni o se devi intervenire entro una data specifica, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。給付に関してご質問があるか、または、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីអត្ថប្រយោជន៍របស់លោកអ្នក ឬត្រូវបានតម្រូវឲ្យអ្នក ចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋ ឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. 귀하의 보험 혜택이나 이 통지서의 요구대로 어느 날짜까지 조처를 취해야만 하는 경우, 제공된 귀하의 주 및 지역 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັ່ງຄ່າ. ຖ້າວ່າ ທ່ານມີຄຳຖາມກ່ຽວກັບຕົນປະໂຫຍດຂອງທ່ານ, ຫຼື ທ່ານຈຳເປັນຕ້ອງດຳເນີນການພາຍໃນວັນທີ່ທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສຳລັບລັດ ຫຼື ເຂດຂອງທ່ານເພື່ອຂໍລົມກັບນາຍພາສາ.

Kajin Majōļ (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjeļọk wōṇāān. Ñe ewōr aṃ kajjitōk kōn jibañ ko aṃ, ak ñe kwoj aikuuj in ṃakūtkūt ṃokta jān juon raan eo eṃōj an kallikkar, kaļọk nōṃba eo ej leļọk ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): Doo bik'é asíníláágo ata' hane' bee níká i'doolwoł. Bee naa áháyánígíí dóó bee níká aná'álwo'ígíí bína'ídílkidgo, éí doodago náás yoołkáálgi hait'éegoda í'díílíił ni'di'nígo, bik'ehgo béésh bee hane'í naaltsoos bikáá'íjį' hodíilnih nitsaa hahoodzojį' éí doodago aadi nahós'a'di áko ata' halne'í bich'į' hadíídzih.

नेपाली (Nepali): तपाईले कुनै खर्च बिना आफ्नो भाषामा सहायता पाउने अधिकार छ। यदि सुविधाहरूका बारेमा तपाईको कुनै प्रश्नहरू भए, अथवा कुनै निर्धारित मिति भित्र तपाईले कुनै कारवाही गर्न आवश्यक भए, कुनै दोभाषेसँग कुरा गर्न तपाईको राज्य वा क्षेत्रका लागि उपलब्ध नम्बरमा फोन गर्नुहोस्।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee tajaajila keetii ilaalchisee gaaffii yoo qabaatte, yookaan yoo guyyaa murtaa'e irratti tarkaanfii akka fudhattu gaafatamte, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره مزایای خود سؤالی داشته یا لازم است تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

Iokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng kosoandi me pid kamwau pe kan, de anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr (insert number here) ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre seus benefícios, ou caso seja necessário que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

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ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸ਼ੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੇ ਫਾਇਦਿਆਂ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de beneficiile dumneavoastră sau vi se solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно ваших преимуществ либо необходимо выполнение каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua fua se fesoasoani i lou lava gagana. Afai e iai ni fesili e uiga i ou penefiti, pe e manaomia onae gaioi a o le'i oo i se aso filifilia, vili le numera ua saunia atu mo lou setete po o vaipanoa e talanoa i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de sus beneficios o si se le solicita que tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong mga benepisyo o kinakailangan mong magsagawa ng aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับสิทธิประโยชน์ของท่าน หรือท่านจำเป็นต้องดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'i ai ho totonu ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i 'o fekau'aki mo ho ngaahi penefiti, pe ko ha me'a na'e fiema'u ke fai ki ha 'aho na'e tukupau atu ke fakahoko ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua ke talanoa mo ha fakatonulea.

Українська (Ukrainian): У Вас є право на отримання допомоги на Вашій рідній мові безкоштовно. Якщо Ви маєте питання стосовно Ваших переваг, чи якщо Вам необхідно здійснити певну дію до конкретної дати, подзвоніть по номеру телефону, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اُردو (Urdu): آپ کو کوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنے فوائد کے متعلق کوئی سوالات ہیں، یا آپ کو ایک مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہے تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về các lợi ích của mình, hoặc quý vị được yêu cầu thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti gba ìrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Tí o bá ní ìbéèrè nípa àwọn ànfàní rẹ tàbí o ní láti gbé igbésẹ kan ní ọjọ́ kan pàtó, pe nọ́mbà tí a pèsè fún ìpínlẹ̀ rẹ tàbí agbègbè láti bá òṣìṣẹ́ kan sọ̀rọ̀.

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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.

"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 balanced 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.

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.