SCL Health

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

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Introduction

This is not an insured benefit plan. Plan benefits are self-insured by Sisters of Charity of Leavenworth Health System (SCL Health), 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.

Sisters of Charity of Leavenworth Health System (SCL Health) (the "Plan Sponsor") is pleased to sponsor a medical plan known as the **SCL Health Medical Plan** (the "Plan").

The Plan covers and pays for the benefits described in this Summary Plan Description (SPD). 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 document has been written so that it is not just a summary of Plan benefits, but also the legal plan document written so that it can be used by you or the Plan Sponsor in understanding and administering the benefits provided under the Plan. This document is effective as of January 1, 2022 and replaces all prior versions. This document and the SCL Health Associate Health Benefit Plan constitute the formal plan document for the Plan.

The Plan Sponsor reserves the right to amend, reduce, suspend or terminate any of the terms of the Plan.

The Plan is an exclusive provider organization plan (EPO). Therefore, you must receive all Covered Services from Network Providers, except that you can receive covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care from non-Network Providers as described in the "Emergency, 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 the Colorado Kaiser Permanente Region. 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

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.

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 SPD.

SCL Health Systems

Deductible EPO National Benefit Summary

KP Use only: Plan IDs ESD91

Effective Date: 1/1/2022

This is a Benefit Summary for your Kaiser Permanente DEPO Plan

OVERALL PLAN FEATURES

Plan Accumulation Type	Calendar Year
Plan Deductible Individual Family 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.	 $750 $1,500
Plan Deductible Accumulates to Out-of-Pocket (OOP) Maximum	**Yes**
Annual Out-of-Pocket Maximum Individual Family 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.	 $2,000 $4,000

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 Exams and Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Preventive Exams and Services 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
Wellness Exams – Children	$0	No	No
Preventive Screenings	$0	No	No
Immunizations (Preventive) Adults and Children.	$0	No	No
Educational and nutritional counseling for diabetes	$0	No	No
Skin cancer screenings	$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	$25	No	Yes
Specialty Care	$40	No	Yes
Referred Hospital Clinic Visits			
Primary Care	$25	No	Yes
Specialty Care	$40	No	Yes
Facility Clinic Charges	15%	Yes	Yes
Telemedicine	$0	No	Yes
Allergy Office visit Cost Share may apply			
Injection	$10	No	Yes
Testing	$40	No	Yes
Serum only	$0	No	Yes
Biofeedback Services Medical and Mental Health Services			
Mental Health or Primary care provider	$25	No	Yes
Specialty provider	$40	No	Yes
Cardiac Rehab	$40	No	Yes
Chemotherapy Services	$40	No	Yes
Dialysis Services	$40	No	Yes
Home Dialysis	$0	No	Yes
Hearing Exam Audiometry exam	$40	No	Yes
Infusion Services Requires skilled or medical administration Office visit Cost Share may apply			
Infusion Primary Care	$25	No	Yes
Infusion Specialty Care	$40	No	Yes
Home Infusion Infusion materials, drugs and supplies	15%	Yes	Yes
Injections and Immunizations Non-routine **Office visit Cost Share may apply**			
Injection Primary Care	$25	No	Yes
Injection Specialty Care	$40	No	Yes
Family Planning Counseling for natural family planning (periodic abstinence). Mirena IUD for Medically Necessary i.e., non-contraception only* (includes professional services required for administration or placement)			
Primary Care	$25	No	Yes
Specialty Care	$40	No	Yes
Counseling, provision and administration of contraceptives* *Check with KPIC regarding payment for these services.	Not covered	N/A	N/A
Male Sterilization			
Office Visit	Not covered	NA	NA
Outpatient Surgery	Not covered	NA	NA
Nutrition Visits			
Primary Care	$25	No	Yes
Specialty Care	$40	No	Yes
Radiation Therapy	$40	No	Yes

Pulmonary Therapy	$40	No	Yes
Respiratory Therapy	$40	No	Yes
Vision Refraction Exam NOTE: Medical care for eye illness or injury is covered under the medical benefit by provider specialty	Not covered	N/A	N/A
HOSPITAL / SURGERY SERVICES			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Inpatient Hospital Includes room and board for private and semi-private rooms; ICU/CCU, Acute Rehab, Inpatient Professional Services, Ancillary Services, and Supplies.			
Per admission - Tier 1 Cost share applies at Denver SCL Health facility**	15%	Yes	Yes
Per admission - Tier 2 Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only	40%	Yes	Yes
Per admission - Tier 2 Cost share applies to all other services	15%	Yes	Yes
Ambulance			
Emergency Ground and Air Ambulance	15%	Yes	Yes
Scheduled Ground and Air Ambulance	15%	Yes	Yes
Non-Network or Network Hospital to Network Hospital (repatriation)	No charge	No	Yes
Emergency Services Accident and Illness	$150	No	Yes
Coinsurance applies after Copay	15%	No	Yes
Copay waived if admitted	Yes	N/A	N/A
Urgent and After Hours Care Urgent Care and After Hours settings	$50	No	Yes
Coinsurance applies after Copay	15%	No	Yes
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.			
Tier 1 Cost share applies at Denver SCL Health facility** or KP Ambulatory Surgery Center	15%	Yes	Yes
Tier 2 Cost share applies for any other Outpatient facility. 30% outpatient facility applies to facility bill only	30%	Yes	Yes
Tier 2 Cost share applies to all other services	15%	Yes	Yes
Abortion			
Elective Termination of Pregnancy	Not Covered	N/A	N/A
Non-Elective Termination of Pregnancy			
Primary Care	$25	No	Yes
Specialty Care	$40	No	Yes
Outpatient Surgery	-	-	-
Tier 1 Cost share applies at Denver SCL Health facility** or KP Ambulatory Surgery Center	15%	Yes	Yes
Tier 2 Cost share applies for any other Outpatient facility. 30% outpatient facility applies to facility bill only	30%	Yes	Yes

Tier 2 Cost share applies to all other services	15%	Yes	Yes
Inpatient Hospital Per admission - Tier 1 Cost share applies at Denver SCL Health facility** Per admission - Tier 2 Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only Per admission - Tier 2 Cost share applies to all other services	 15% 40% 15%	 Yes Yes Yes	 Yes Yes Yes
Bariatric Surgery Outpatient Surgery Tier 1 Cost share applies at Denver SCL Health facility** or KP Ambulatory Surgery Center Tier 2 Cost share applies for any other Outpatient facility. 30% outpatient facility applies to facility bill only Tier 2 Cost share applies to all other services Inpatient Hospital Per admission - Tier 1 Cost share applies at Denver SCL Health facility**	 15% 30% 15% 15%	 Yes Yes Yes Yes	 Yes Yes Yes Yes
Per admission - Tier 2 Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only	40%	Yes	Yes
Per admission - Tier 2 Cost share applies to all other services	15%	Yes	Yes
Temporomandibular Surgery (TMD/TMJ) Outpatient Surgery Tier 1 Cost share applies at Denver SCL Health facility** or KP Ambulatory Surgery Center Tier 2 Cost share applies for any other Outpatient facility. 30% outpatient facility applies to facility bill only Tier 2 Cost share applies to all other services Inpatient Hospital Per admission - Tier 1 Cost share applies at Denver SCL Health facility**	- 15% 30% 15% 15%	- Yes Yes Yes Yes	- Yes Yes Yes Yes
Per admission - Tier 2 Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only	40%	Yes	Yes
Per admission - Tier 2 Cost share applies to all other services	15%	Yes	Yes
Gender Affirming Surgery Covered upper and lower body gender confirming surgeries Outpatient Surgery Tier 1 Cost share applies at Denver SCL Health facility** or KP Ambulatory Surgery Center	 15%	 Yes	 Yes

Tier 2 Cost share applies for any other Outpatient facility. 30% outpatient facility applies to facility bill only	30%	Yes	Yes
Tier 2 Cost share applies to all other services	15%	Yes	Yes
Inpatient Hospital			
Per admission - Tier 1 Cost share applies at Denver SCL Health facility**	15%	Yes	Yes
Per admission - Tier 2 Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only	40%	Yes	Yes
Per admission - Tier 2 Cost share applies to all other services	15%	Yes	Yes
Organ Transplants Organ acquisition, diagnostic testing for donor and recipient			
Outpatient Surgery			
Tier 1 Cost share applies at Denver SCL Health facility** or KP Ambulatory Surgery Center	15%	Yes	Yes
Tier 2 Cost share applies for any other Outpatient facility. 30% outpatient facility applies to facility bill only	30%	Yes	Yes
Tier 2 Cost share applies to all other services	15%	Yes	Yes
Inpatient Hospital			
Per admission - Tier 1 Cost share applies at Denver SCL Health facility**	15%	Yes	Yes
Per admission - Tier 2 Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only	40%	Yes	Yes
Per admission - Tier 2 Cost share applies to all other services	15%	Yes	Yes
Travel and Lodging for Organ Transplants and Gender Affirming Surgery Organ Transplants include recipient, care giver and donor. Gender Affirming surgery include patient and companion			
Transportation Limits	None	N/A	N/A
Lodging Limits	None	N/A	N/A
Daily Expense Limits Daily expenses include incidental expenses such as meals and does not include personal expenses.	Reimbursement up to $50 per day per person	N/A	N/A
Benefit Maximum	None	N/A	N/A
Benefit Lifetime Maximum	$10,000	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			
Visit to confirm pregnancy - Primary Care	$25	No	Yes
Visit to confirm pregnancy - Specialty Care	$40	No	Yes
Pre-natal and first post-partum visit	$0	No	No

Hospital Inpatient Includes contracted Birthing Center if available			
Per admission - Tier 1 (facility) Includes Well baby facility fees when billed with mother. Cost share applies at Denver SCL Health facility**	15%	Yes	Yes
Per admission - Tier 2 (facility) Includes Well baby facility fees when billed with mother. Cost share applies for any other Plan Hospital. 40% inpatient facility applies to facility bill only.	40%	Yes	Yes
Per admission - Tier 2 (facility) Includes Well baby facility fees when billed with mother. Cost share applies to all other services.	15%	Yes	Yes
Well Newborn (facility and professional services when billed separately from the mother)	$0	No	Yes
DIAGNOSTIC TESTS & PROCEDURES Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings: These Services are treated the same as Lab and X-ray Services in this section.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Diagnostic Lab & X-ray	15%	Yes	Yes
High Tech/Advanced Radiology - CT, MRI, Nuclear Medicine and PET	15%	Yes	Yes
Mammogram (diagnostic)	$0	No	Yes
Bone Density Scan (diagnostic). Limited to one per year	$0	No	Yes
FERTILITY SERVICES			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Hospital Charges			
Per admission	Not Covered	N/A	N/A
Office Visit	Not Covered	N/A	N/A
Diagnostic Lab & X-ray	Not Covered	N/A	N/A
Outpatient Hospital or Ambulatory Surgery Center	Not Covered	N/A	N/A
Iatrogenic Fertility Preservation	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 (Including Residential treatment services)			
Per admission	15%	Yes	Yes
Partial Hospitalization			
Per episode	15%	Yes	Yes
Mental Health - Intensive Outpatient, per day Includes all Services provided during the day	$25	No	Yes
Mental Health – Outpatient/Office			
Individual Visit Cost Share, per day	$25	No	Yes
Group Visit Cost Share, per day	$12	No	Yes
Substance Use Disorder Services Inpatient (Including Residential treatment services) Detox covered under medical benefits			
Per admission	15%	Yes	Yes

Substance Use Disorder Services - Partial Hospitalization			
Per episode	15%	Yes	Yes
Substance Use Disorder Services, per day **- Intensive Outpatient** Includes all Services provided during the day.	$25	No	Yes
Substance Use Disorder Services – Outpatient/Office			
Individual Visit Cost Share, per day	$25	No	Yes
Group Visit Cost Share, per day	$12	No	Yes

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

Outpatient Cost Share for Rehabilitative and Habilitative therapies are applied as one Copay per provider per day. Visits are counted on a 'per visit' basis.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Physical Therapy	$40	No	Yes
Visit Maximum	Unlimited	N/A	N/A
Occupational Therapy	$40	No	Yes
Visit Maximum	Unlimited	N/A	N/A
Speech Therapy	$40	No	Yes
Visit Maximum	Unlimited	N/A	N/A

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Home Health Care Nurse visits (2 hrs), Aide visits (4 hours), therapy visits, supplies associated with a visit	15%	Yes	Yes
Visit Maximum	100 visits per calendar year	N/A	N/A
Hospice	$0	Yes	Yes
Respite Care for Home Hospice	$0	Yes	Yes
Respite Care Maximum	Up to five consecutive days for each approved admission	N/A	N/A
Skilled Nursing Facility			
Per admission	15%	Yes	Yes
Day Maximum	100 days per calendar year	N/A	N/A

OTHER Services

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Acupuncture Self referred	$40	No	Yes
Visit Maximum	20 visits per calendar year	N/A	N/A
Chiropractic Care Self referred	$40	No	Yes
Visit Maximum	20 visits per calendar year	N/A	N/A
Autism A diagnosis of ASD is required for benefits to apply			
Applied Behavioral Analysis	$25	No	Yes
Age Limit	N/A	N/A	N/A
Physical/Occupational/Speech Therapy	$40	No	Yes
Visit maximum	Unlimited	N/A	N/A
Note: Long term rehabilitation for Physical, Occupational and Speech therapy in a Plan Medical Office is covered for Autism Spectrum Disorders when prescribed by a Plan Physician.			
Durable Medical Equipment Including Diabetic testing supplies and equipment	15%	Yes	Yes
Peak Flow Meters	15%	No	Yes

Prosthetics and Orthotics Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies.	15%	Yes	Yes
Prosthetics - Wigs and Toupees To replace hair lost due to cancer or anemia	15%	Yes	Yes
Benefit Allowance	$350	Yes	Yes
Allowance frequency	Annually	N/A	N/A
Hearing Aids Includes tests to determine appropriate model, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted			
Benefit Allowance	$3,000	No	No
Allowance frequency	every 36 months after date of purchase	N/A	N/A
Out of Area Benefit: (for dependents only)			
Office Visit Primary care, Specialty, Mental Health/Chemical Dependency, Well Child prevention, Gyn and Allergy injection visits, immunizations are covered. All other visits not covered.			
Primary Care	$25	No	Yes
Well Child Preventive	$0	No	Yes
Office Visit limits (procedures and labs are excluded)	5 per calendar year	N/A	N/A
Flu shots	$0	No	Yes
Diagnostic X-ray (X-ray and Ultrasound only)	20%	Yes	Yes
Diagnostic X-ray Service limits (X-ray and Ultrasound only)	5 per calendar year	N/A	N/A
Physical, Occupational & Speech Therapies	$40	No	Yes
Visit Maximum	up to 5 combined physical. Occupational and speech therapy visits per plan year	N/A	N/A
Prescription Drug	= Brand/Generic/Non-Formulary	No	Yes
ACA Mandated Drugs	$0	No	No
Diabetic testing supplies (test strips)	= Brand/Generic/Non-Formulary	No	Yes
Medical Foods Amino acid modified products	$0	No	Yes
Vision Hardware for Adults - Contact Lenses, Frames and Eyeglass Lenses	Not Covered	N/A	N/A

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
Retail Drugs ***3 Tier Retail***			
Generic	$10 up to 30 days' supply; $20 31-60 days' supply; $30 61-90 days' supply	No	Yes
Brand	$50 up to 30 days' supply $100 31-60 days' supply $150 61-90 days' supply	No	Yes

Non-Formulary Brand	50% up to a maximum of $125 up to 30 days' supply; 50% up to a maximum of $250 31-60 days' supply; 50% up to a maximum of $375 61-90 days' supply	No	Yes
Specialty Tier - Only dispensed by Franklin Pharmacy at St. Joseph Hospital	25% for specialty Rx, including Self-Administered injectables and oral drugs, up to a maximum of $250 per Rx, 30-day supply	No	Yes
NOTE: Certain medications may be limited to 30-day supply			
Mail Order Drugs ***3 Tier Mail Order***			
Generic	$10 up to 30 days' supply and $20 from 31 up to 90 days' supply	No	Yes
Brand	$50 up to 30 days' supply and $100 from 31 up to 90 days' supply	No	Yes
Non-Formulary Brand	50% up to a maximum of $125 up to 30 days' supply; 50% up to a maximum of $250 31-90 days' supply;	No	Yes
Specialty Tier	25% for specialty Rx, including Self-Administered injectables and oral drugs, up to a maximum of $250 per Rx, 30-day 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 (DME)			
Diabetic Medication (Formulary and approved non-formulary brand insulin and diabetic medications)	Retail: $25 up to 30 days' supply $50 from 31 - 60 days' supply $75 from 61 - 90 days' supply Mail Order: $25 up to 30 days' supply $50 from 31 - 90 days' supply	No	Yes
Diabetic testing supplies (meters, test strips)	=Generic/Brand Cost Share	No	Yes
Diabetic administration devices (syringes)	=Generic/Brand Cost Share	No	Yes
Fertility Drug Coverage	Not covered	N/A	N/A
Sexual Dysfunction	Not covered	N/A	N/A
End of Life Drugs	Not covered	N/A	N/A
Weight Loss	=Generic/Brand Cost Share	No	Yes
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis and stroke	=Generic/Brand Cost Share	No	Yes
ACA Mandated Drugs* (see Preventive Services for more information)			
Contraceptive Devices (diaphragms, cervical caps, etc.) **and Contraceptive Drugs**	Not covered*	No	No
Emergency Contraception	Not covered*	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, female condoms, emergency contraceptives and sponges)	Not covered*	N/A	N/A
Bowel Prep	$0	No	No
COVID-19 Test kit	$0	No	No
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.			
***With prescription, no Cost Share. Without prescription, participant pays retail cost.			
Refer to the Outpatient Prescription Drug section later in this document for coupon information.			
*Check with KPIC regarding payment for these services.			
**SCL Health Denver facilities:			
Lutheran Medical Center Platte Valley Medical Center			
Exempla Physician Network			
Good Samaritan Medical Center			
Saint Joseph Hospital			
Children’s Hospital of Colorado			

HEALTH REIMBURSEMENT ACCOUNT INFORMATION

This document is the SPD for the SCL Health Medical Plan (as administered by KPIC), which includes a Health Reimbursement Arrangement or "HRA." Read this document carefully, including the information provided below regarding your HRA, so you understand the benefits under this Plan. Many of its provisions are interrelated; reading just one or two provisions may give you a misleading impression. If you have any questions after reading it, the Claims Administrator may be able to help you find the answers. If there is a conflict between the SPD and any summaries provided to you, the SPD will control.

Health Reimbursement Account Information
When you enroll in this Plan, a Health Reimbursement Account (HRA) is created for you. You can use the funds credited to your HRA to help you pay for some of the costs of your covered medical expenses.

Your HRA is a bookkeeping account and does not represent assets that are actually set aside for the exclusive purpose of providing benefits under the Plan. The benefits provided under the Plan, including amounts paid from your HRA, are paid out of the general assets of the Employer. You do not have any right, title or claim to any assets prior to their payment hereunder. HRA accounts are subject the claims of the Employer's creditors.

You may earn credits to your HRA by your and, if applicable, your spouse's or LDA's participation in the Employer's wellness program. You received separate information regarding this program and what activities you can complete to earn HRA credits (and other benefits). Additional information on how to complete these activities to receive your earned incentive dollars can be found at **www.sclhealthbenefits.org/healthy-living/**

You are not permitted to make any contributions to your HRA, whether made on a pre-tax or after-tax basis.

You may elect when and how your HRA credits or "Benefit Dollars" are used, however, they may only be used for Covered Services as defined in this document. If you don't spend all your HRA Benefit Dollars in a plan year and you re-enroll in the Plan (under this Kaiser option or a CIGNA option) for the following year, any remaining HRA balance rolls over into the Benefit Dollars for the next plan year. (The only exception to this is that if you move from the CIGNA CDHP option, your "seed" money will not roll over to this Kaiser option or the CIGNA PPO option.)

If you do not enroll in SCL Health's medical plan next year or you cease to be actively employed, your HRA Benefit Dollars will be forfeited, unless you elect to continue your medical coverage under COBRA.

You can keep track of the Benefit Dollars in your HRA by going online to www.kp.org/healthpayment or by calling the toll-free number on the back of your ID card.

Using the Benefit Dollars in your HRA

You have two options for accessing your HRA funds:

1. **Debit Card**: You will receive a debit card in the mail shortly after your enrollment. You can begin using this card when your coverage on the plan goes into effect. Once activated, your card can be used just like a typical credit or debit card when you are paying for covered medical services at the point of sale with a qualified provider (such as at a doctor's office or pharmacy).
2. **File a Claim**: You can also submit expenses for reimbursement through your medical plan vendor. Once reviewed and approved, you will receive a check in the mail with funds drawn on your HRA account.

You can use your HRA Benefit Dollars to pay for:

- Covered Medical and Pharmacy Services;
- Copays;
- Deductible;
- Coinsurance.

Note:

- While an HRA and Flexible Spending Account (FSA) may cover some of the same types of expenses, an FSA may be funded with pre-tax contributions under a salary reduction arrangement.

Definitions

In this SPD, Participants and Dependents may be referred to as “you” or “your.”

The following terms, when capitalized and used in this SPD, 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, and
- A rescission of coverage (i.e. a cancellation or discontinuance of coverage that has retroactive effective other than because of the failure to pay premiums).
- 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 as a result 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.

Associate: A common law employee of an Employer.

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.

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 for coverage described in this SPD.

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 about 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: Dependent means:

- The eligible Associate's lawful spouse.

- The eligible Associate's "Legally Domiciled Adult" or "LDA."
    - Category A LDA ("LDA A") -- (1) has lived with the Associate continuously for at least 12 months, (2) has an on-going, exclusive and committed relationship with the Associate similar to marriage (e.g., is not a casual roommate or tenant), (3) shares basic living expenses and is financially

interdependent with the Associate, and (4) is neither legally married to (or legally separated from) or in a civil union with anyone else, nor legally related to the Associate by blood in any way that would prohibit marriage in the state of his or her residence; OR

- Category B LDA ("LDA B") -- (1) is the Associate's adult child, sibling or parent by blood, adoption, or marriage (e.g., a step-child), (2) the Associate claimed the individual as a dependent on his or her federal income tax return for the preceding year, (3) has lived with the Associate continuously for at least 6 months; and (4) is not eligible for other coverage under another employer's group health plan or under Medicare (unless the individual has Medicare based on disability).

- The eligible Associate's or covered LDA Category A's child under the age of 26.

- The eligible Associate's or covered LDA Category A's child over the age of 26, unmarried, and primarily supported by the Associate and incapable of self-sustaining employment because of mental or physical disability which has been determined to be a disability by the Social Security Administration (SSA) and which arose while the child was covered as a dependent under this Plan, or while covered as a dependent under a prior plan, with no break in coverage.

  You must provide your child's SSA Certificate of Disability from time to time, but not more frequently than once a year, and you may be required to provide proof of the continuation of such condition and dependence.

  The term "child" for the preceding two bullets points means the Associate's or covered LDA A's natural or legally adopted child. It also includes a stepchild or a child for whom the Associate or LDA A is the legal guardian. A child of the Associate's LDA B is not eligible to participate in the Plan.

No one may be covered as a Dependent and also as an Associate under this plan. If both parents are covered as Associates, children may be covered as Dependents of one parent only. A child under age 26 may be covered as either an Associate or as a Dependent child. An individual cannot be covered as an Associate while also covered as a Dependent of an Associate.

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 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 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, 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.

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

Employer: The term Employer means SCL Health and any related entity that has adopted this Plan with the consent of SCL Health for the benefit of its eligible associates.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

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.

Initial Measurement Period or "IMP": Your Initial Measurement Period means the period beginning on the first day of the first payroll period that begins after your date of hire and ending on the last day of the payroll period that ends immediately before the 12-month anniversary of your date of hire.

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 administrative services for the Plan.

Legally Domiciled Adult or "LDA": An LDA means an individual over the age of 18 who has lived in the same principal residence as the Associate and remains a member of the Associate's household throughout the coverage period; and who:

- Category A LDA (LDA A) – (1) has lived with the associate continuously for at least 12 months, (2) has an on-going, exclusive and committed relationship with the associate similar to marriage (e.g., is not a casual roommate or tenant), (3) shares basic living expenses and is financially interdependent with the associate, and (4) is neither legally married to (or legally separated from) or in a civil union with anyone else, nor legally related to the associate by blood in any way that would prohibit marriage in the state of his or her residence.

- Category B LDA (LDA B) – (1) is the associate's adult child, sibling or parent by blood, adoption, or marriage (e.g., a step-child), (2) the associate claimed the individual as a dependent on his or her federal income tax return for the preceding year, (3) has lived with the associate continuously for at least 6 months, and (4) for purposes of electing medical plan coverage, is not eligible for other coverage under another employer's group health plan or under Medicare (unless the individual has Medicare based on disability).

An Associate may cover a maximum of two adults under the Plan, including himself or herself, in addition to any dependent children under age 26 or disabled. For instance, an Associate who is married and covers his or her spouse cannot also cover an LDA B.

Medically Necessary: A Service is Medically Necessary if, in the judgment of a Kaiser Permanente on behalf of the Plan, 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 http://providers.kaiserpermanente.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 the *Locate Our Services* tab, select your region, and then select the *Facilities* tab.

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 as long as it continues to meet the definition.

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

Out-of-Pocket Maximum: The maximum dollar amount you can be required to pay for certain Covered Services you receive during a calendar year. 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 of his or her relationship to someone else.

Plan: The Plan named in the "Legal and Administrative Information" section.

Plan Sponsor: The plan sponsor named in the "Legal and Administrative Information" section.

Plan Year: The period 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.

PPACA Effective Date: PPACA Effective Date means the first day of the applicable Stability Period.

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.

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

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

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

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

Stability Period: With respect to an Initial Measurement Period, the Stability Period means the 12-month period beginning on the first day of the month following the end of such Initial Measurement Period (unless the period between the end of the Initial Measurement Period and the first day of the following month is less than two weeks, in which case the Stability Period begins the first day of the second month following the end of the Initial Measurement Period). With respect to a Standard Measurement Period, the Stability Period means the following Plan Year.

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.

Standard Measurement Period: The Standard Measurement Period begins with the payroll period that overlaps or starts on November 1 and ends on the last day of the payroll period that ends immediately before the 12-month anniversary of that date. Subsequent Standard Measurement Periods will begin on the date following the end of the preceding Standard Measurement Period.

Surprise Billing: Unexpected balance billing (except when you have consented) for emergency, certain other Services performed by a Non-Network provider at a Network facility and air ambulance services. 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, the Recognized Amount is the Qualifying Payment Amount or if applicable, the All Payer Model amount or state law.

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

Except as specifically noted, you are eligible for coverage under the Plan if you have a payroll status of Full Time Equivalency (FTE) of 0.5 or above.

The following individuals are not eligible to participate in the Plan: individuals classified as “PRN,” “Per Diem,” “Temporary,” student interns, volunteers, or any person classified as an independent contractor or a leased employee, regardless of whether such individual is subsequently determined by a court of competent jurisdiction or governmental agency or authority to have been a common law employee.

Notwithstanding the preceding, any individual classified as an Associate who is not otherwise eligible under the rules stated above will be eligible to participate in the Plan during the applicable Stability Period if he or she averages at least 30 hours per week during either his or her Initial Measurement Period or a Standard Measurement Period.

If you are an eligible Associate and you elect coverage under the Plan, you may also elect coverage under the Plan for your eligible Dependents.

NOTE: To have coverage under the Plan, you must also meet the service area eligibility requirements explained below.

When You Can Enroll and When Coverage Begins

If you are eligible upon hire, your coverage will be effective the first of the month following your date of hire or, with respect to resident physicians, on the date of hire as an eligible Associate, if you enroll within 31 days of your date of hire.

Notwithstanding the above, if you are otherwise not eligible to participate in the Plan but become eligible because you averaged at least 30 hours per week during your Initial Measurement Period or during a Standard Measurement Period, your coverage will be effective on your PPACA Effective Date.

Effective Date of Dependent Coverage.

Coverage for your Dependents will be effective on the same date as your coverage is effective, if you timely elect when you first become eligible, or the first day of the next plan year if you elect coverage during an annual open enrollment period.

New Dependent effective date of coverage

Any Dependent child born or newly adopted while you are covered by the Plan will be covered on the date of his or her birth if you elect Dependent coverage no later than 60 days after the birth or adoption. If you do not elect coverage during

this period, you will not be eligible to enroll your child until the next open enrollment period, or if you experience another Qualified Life Event throughout the plan year.

Service Area eligibility requirement

The Participant must live or work in a Kaiser Service Area at the time of enrollment. The Service Areas are listed in the back of this SPD. 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 care or Emergency Services 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.

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. The annual open enrollment period will occur before the end of each calendar year. Elections and changes made during an open enrollment period will be effective as of the first day of the following calendar year.

Persons barred from enrolling

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

(1) Threatening the safety of Provider personnel or any person or property at a Network Facility.
(2) Committing theft from a Network Provider or at a Network Facility.
(3) Performing 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.

Mid-year changes

The Plan Sponsor has adopted the SCL Health Flexible Benefit Plan in accordance with the Section 125 regulations of the Internal Revenue Code. The Flexible Benefit Plan may allow mid-year changes in enrollment under this Plan. These changes will be subject to the terms of the Flexible Benefit Plan. For more information, see the SCL Health Flexible Benefit Plan.

Approved Leaves of Absence

If you go on any approved leave of absence, your coverage under the Plan generally will continue as though you continued to perform services.

Keep in mind that you will be required to continue paying your premiums for your coverage while you are on leave. If your pay during the leave is not sufficient to cover the applicable premium for that month, you will be separately billed for the premium. If you do not pay the premium within the specified time, your coverage (and that of your covered Dependents) may be terminated. Except for an FMLA leave, you may not reinstate your coverage until the next calendar year (assuming you are otherwise eligible).

If you have coverage under the Plan because you averaged at least 30 hours during your Initial Measurement Period or a Standard Measurement Period, your coverage will continue during the applicable Stability Period even if you are on an approved leave of absence, as long as you continue to timely pay premiums. (Notwithstanding the preceding, if you are on an approved leave of absence for more than six months, your coverage may terminated earlier in accordance with the Employer's leave policy.) Your eligibility for coverage during a subsequent Stability Period will be based on your hours during the relevant Standard Measurement Period. For purposes of this determination, you will receive credit for any period during which you are on an FMLA, USERRA or jury duty leave of absence. You will also receive credit for any paid leave hours. You will not receive credit for other leaves for purposes of this determination..

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.

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.

The Plan 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?WT.mc_id=111220FEATURE3TEXT

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

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

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

Colorado Region

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.

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.

Prior Authorization is required for Services provided by non-Network Providers or non-Network Facilities. A referral for these Services will be submitted by the Network Physician. You will be notified of the determination regarding Authorization for coverage.

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

Required Prior-Authorization List

- All inpatient and outpatient facility services (excluding emergencies)
- Office based habilitative/rehabilitative 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.

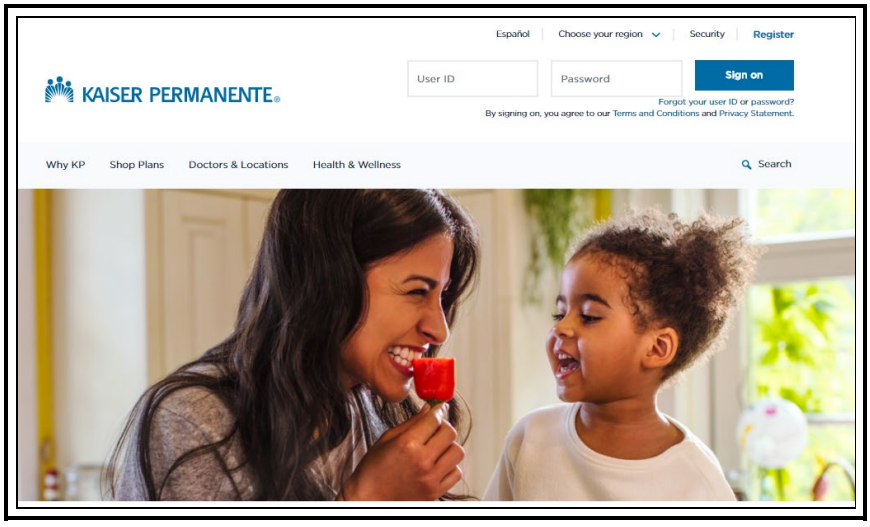
Second Opinions

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

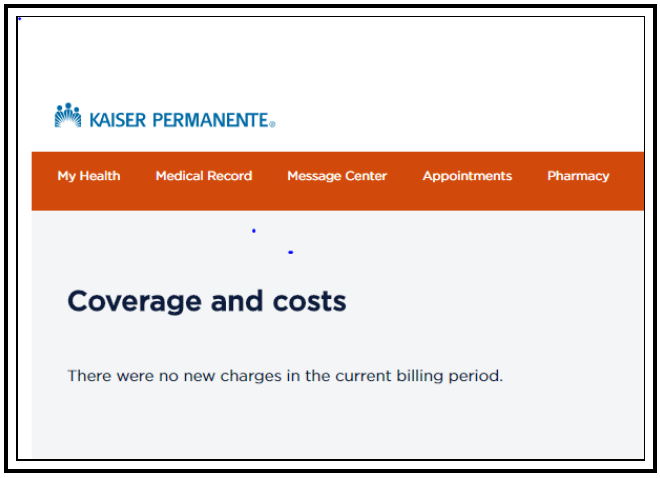
- A Network Physician about any proposed Covered Services or.
- A Non-Network Provider with Prior Authorization.

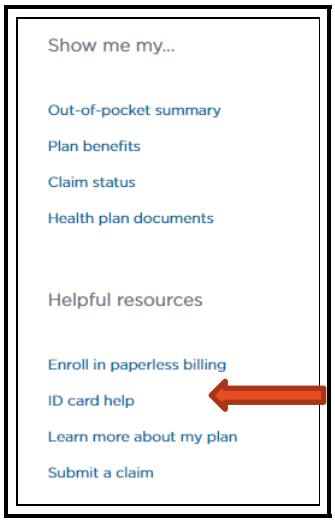
Your Identification Card

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.



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.





Download a Digital ID Card

1. If you haven't already done so, create your online account at **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.

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.

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 the Colorado Kaiser Permanente Service Area and you do not work within the Colorado Kaiser Permanente Service Area you will be required to change your health plan to one that serves your area. Please contact your employer for 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 as described on 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 www.kptargetclinic.org

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 Network and 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:

- 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, 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 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 24hours 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

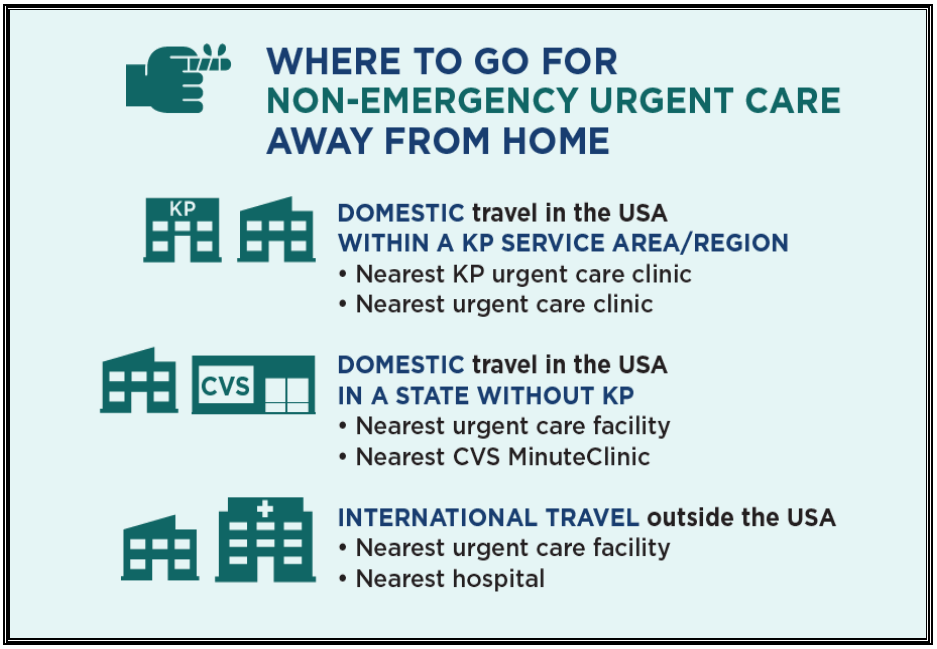
You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you are in the Service Area and think you may need Urgent Care, call the urgent care or advice nurse telephone number (see "Customer Service Phone Numbers" section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

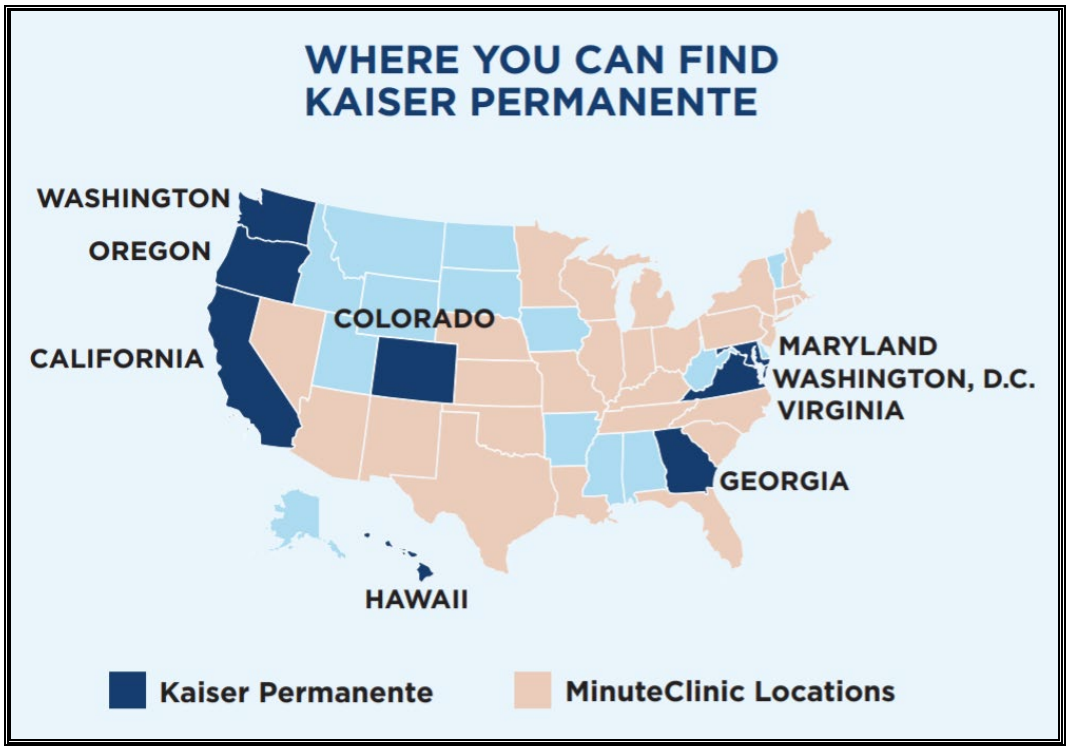
The following Services are not covered under this section:

- 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





- If you get care at a MinuteClinic or any other urgent care facility within a state where Kaiser Permanente operates, you'll be asked to pay up front for services you receive and file a claim for reimbursement. Note: Urgent Care received in Kaiser Permanente Service Areas from a Non-Network provider or emergency department is not covered.
- If you get care as a MinuteClinic outside a state where Kaiser Permanente operates, you'll be charged your standard copay or co-insurance.

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:

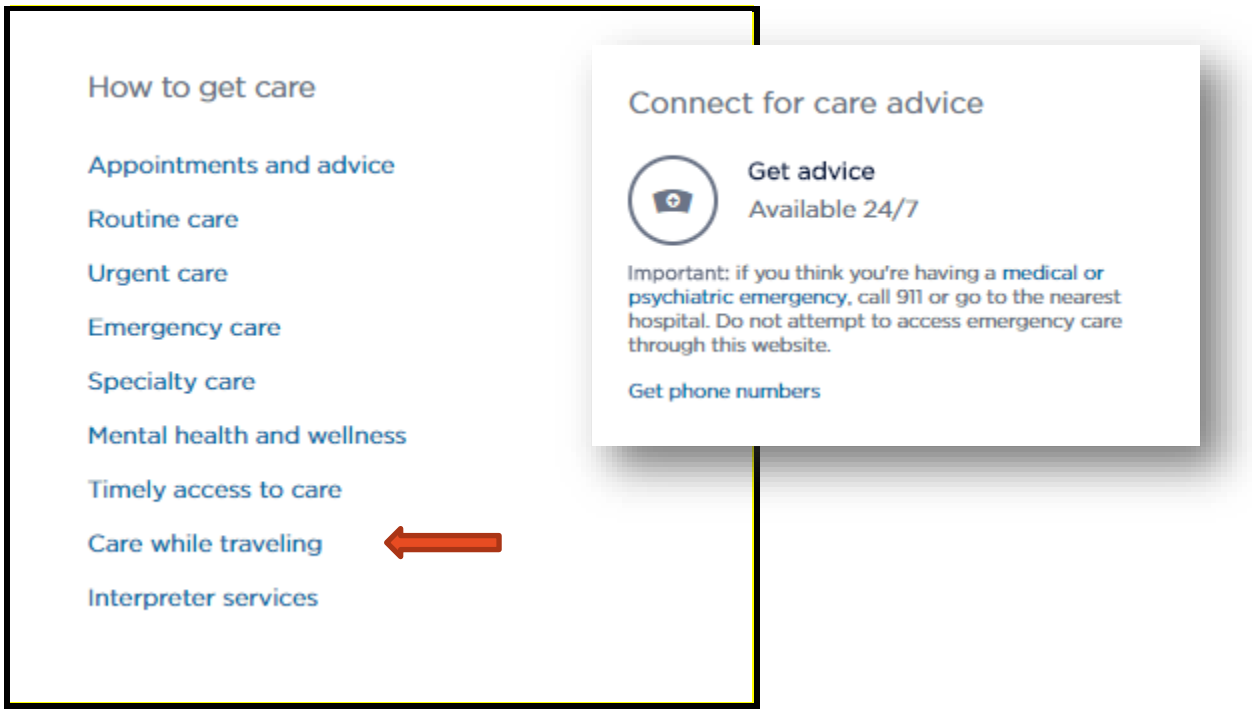
- You receive the Services from Non–Network Providers while you are temporarily outside the Service Area;
- The care cannot be delayed until you return to our Service Area; and
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until 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.

Network Urgent Care is also available outside a state where Kaiser Permanente facilities are located (CA WA, OR GA, VA, MD & DC) from CVS Minute Clinics

TM. To check availability and location log onto www.kp.org or call the KP Advice Nurses.



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.
- The care cannot be delayed until you return to our Service Area; and
- 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 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.

Medical necessity

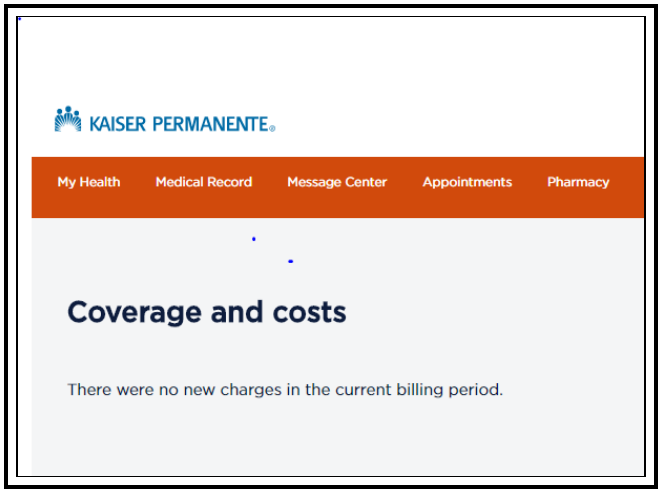
A Kaiser Permanente health professional will determine if services are Medically Necessary for each member.

Cost Sharing (Copayments and Coinsurance)

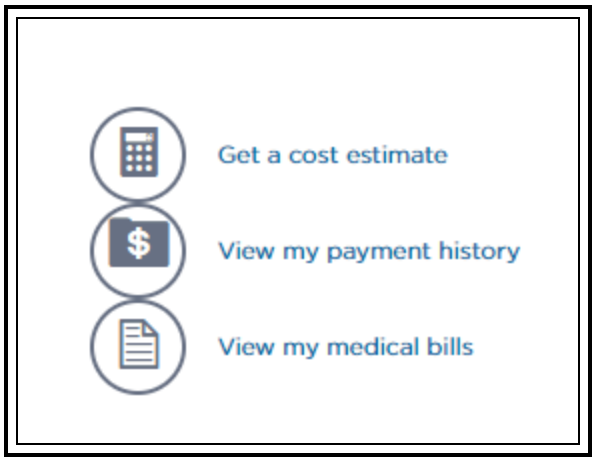
The "Schedule of Benefits" section" describes the Cost Sharing you must pay for Covered Services. Cost Sharing is due at the time you receive the Services, unless Network Providers agree to bill you. For items ordered in advance, you

pay the Cost Sharing in effect on the order date (although the item will not be covered unless you still have coverage for it on the date you receive it). Copayments are applied per provider per day. Unless specified otherwise, when services can be provided in different settings, the Cost Sharing is applied per the place of service in which the care is delivered and according to the type of provider providing the service. For example: if the service is provided during a hospital admission, the Hospital Inpatient Services Cost Share is applied. If the same service is performed in an office setting by a specialist, the specialty care office visit Cost Share is applied. If services are provided in a hospital clinic setting, separate Cost Shares may apply to the hospital clinic charges and the physician charges; both hospital clinic and physician charges will be subject to applicable deductibles and Cost Share. 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 go to www.kp.org then select *Coverage and costs.*



Then select *Get a cost 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” section describes limits, maximums and Allowance applicable to Covered Services. If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.

Plan Year Deductible

Generally, you must pay all of the costs from providers up to the deductible amount before the 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. Once you satisfy the single or family Annual Deductible You pay the Cost Sharing indicated in the “Schedule of Benefits.” The Annual Deductible amounts are listed in the “Schedule of Benefits”.

Plan Year Out-Of-Pocket Maximums

There are limits to the total amount of Cost Sharing you must pay in a calendar year for certain Covered Services that you receive in the same calendar year. Those limits can be found in the “Schedule of Benefits” section.

The Out-of-Pocket Maximum is the most you could pay in a year for covered services. If you have other family member in this Plan, they must meet their own Out-of-Pocket Maximum until the overall family Out-of-Pocket Maximum has been met.

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

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

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
- Acupuncture
- Allergy Services.
- Ambulance
- Bariatric surgery - when you meet certain medical criteria
- Biofeedback
- Blood and blood products and their administration
- Chemotherapy
- Chiropractic care
- Dental Services for Dental Radiation, Dental Anesthesia and 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
- 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
- Maternity - prenatal and postnatal visits
- Outpatient surgery including FDA approved internally implanted Prosthetic devices such as breast implants following a covered mastectomy
- 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

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

Hospital Inpatient Services

The following inpatient Services are covered:

- Acute inpatient rehabilitation including physical, occupational, and speech therapy
- Anesthesia
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs and endoscopic procedures
- Dialysis
- Dressings and medical supplies used or applied during an inpatient hospital admission
- Drugs that require administration or observation by medical personnel
- Network Physician Services, including consultation and treatment by specialists
- General nursing care
- Network Physician Services, including consultation and treatment by specialists
- Medical social Services
- Maternity care and delivery (including cesarean section and newborn care)
- Operating and recovery room including FDA approved internally implanted Prosthetic devices such as pacemakers or artificial hips
- Respiratory therapy
- Room and board, including a private room, if Medically Necessary
- Specialized care and critical care units

Acupuncture Services

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

To Locate a Network Provider Contact:

Colorado Region (no acupuncture network–utilize any willing provider)

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 neuromusculoskeletal disorders are covered. Services include plain x-rays and adjunctive therapy associated with spinal, muscle or joint manipulation.

To Locate a Network Provider Contact:
Colorado Region Kaiser Centers for Complementary Medicine
1-844-800-0788 or 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:
        - It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
        - 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 underage 7;
- You are developmentally disabled;

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

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

Exclusions:

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

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 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 and 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 aniridi.

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 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 Copayments for emergency Services are waived when you are directly admitted to the hospital from the Emergency Department.

Hearing Aids

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
- Allowance renews every 36 months.

You do not need to use the allowance all at once. The maximum benefit amount for each Hearing Aid must be used at the initial point of sale. The 36-month period begins at the initial point of sale. Any unused portion of the Allowance at the point of sale may be used up until the allowance renews. 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 36 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.
- 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 is not covered. (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 six (6) 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 vaginal 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.
3) **Newborn child**. Newborns are only covered if enrolled in the Plan; exception well-newborn charges billed as ancillary fees on the mother's hospital bill. Any Dependent child born while you are covered by the Plan will be covered on the date of his or her birth if you elect Dependent coverage no later than 60 days after the birth. If you do not elect coverage during this period, you will not be eligible to enroll your child until the next open enrollment period.

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 prescription originally filled prior to enrollment in the Plan; 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:
     a. Growth hormone;
     b. Smoking Cessation products; or
     c. Drugs used in the treatment of weight control
   - 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

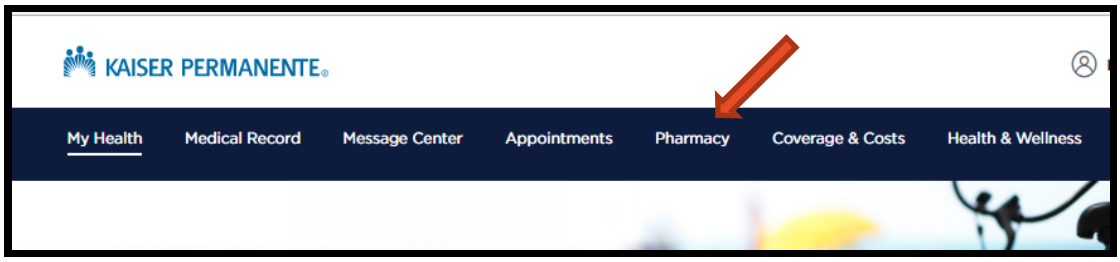
that the item is in limited supply in the market or for specific drugs (the Pharmacy can tell you if a drug you take is one of these drugs).

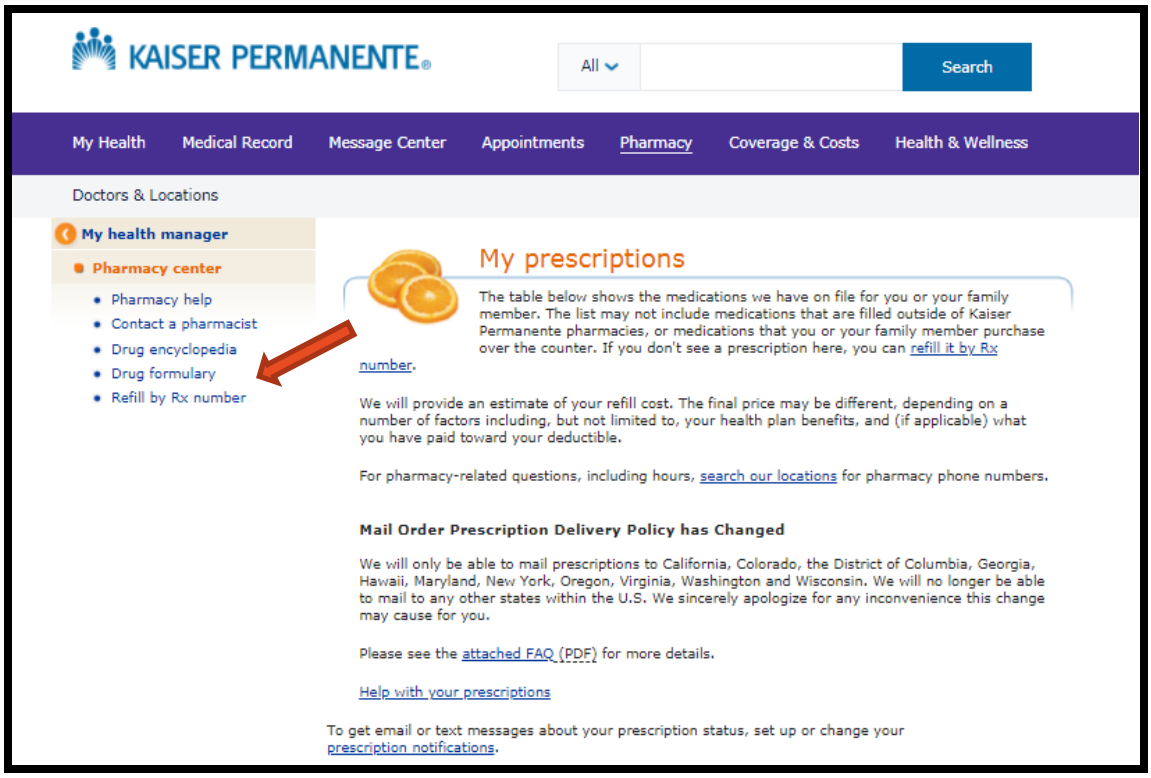
Mail Order Service, subject to any Limitations, Copayments and Deductibles, is available. Not all drugs are available through the mail order service. Examples of drugs that cannot be mailed include:

- 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, visit *www.kp.org* or http://www.optumrx.com or call 1-866-427-7701.

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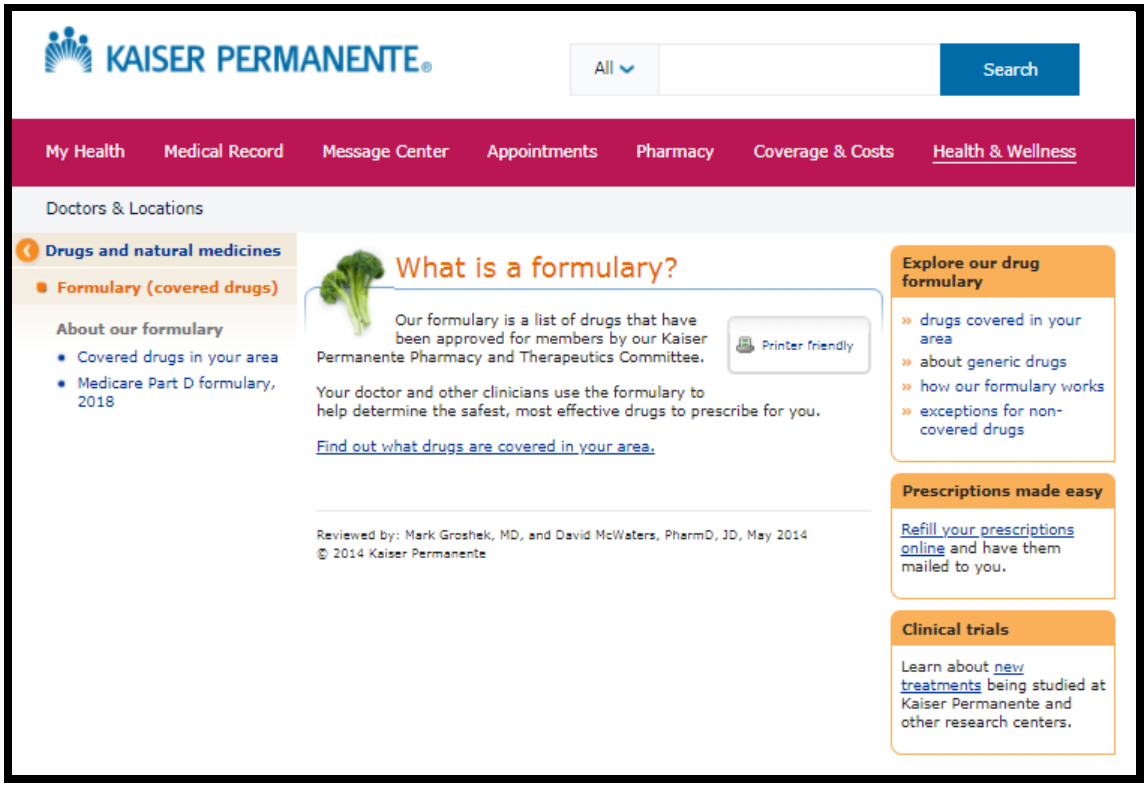
Message Center
Appointments
Pharmacy
Coverage & Costs
Health & Wellness
Doctors & Locations
My health manager
Pharmacy center
Pharmacy help
Contact a pharmacist
Drug encyclopedia
Drug formulary
Refill by Rx number
My prescriptions
The table below shows the medications we have on file for you or your family member. The list may not include medications that are filled outside of Kaiser Permanente pharmacies, or medications that you or your family member purchase over the counter. If you don't see a prescription here, you can refill it by Rx number.
We will provide an estimate of your refill cost. The final price may be different, depending on a number of factors including, but not limited to, your health plan benefits, and (if applicable) what you have paid toward your deductible.
For pharmacy-related questions, including hours, search our locations for pharmacy phone numbers.
Mail Order Prescription Delivery Policy has Changed
We will only be able to mail prescriptions to California, Colorado, the District of Columbia, Georgia, Hawaii, Maryland, New York, Oregon, Virginia, Washington and Wisconsin. We will no longer be able to mail to any other states within the U.S. We sincerely apologize for any inconvenience this change may cause for you.
Please see the attached FAQ (PDF) for more details.
Help with your prescriptions
To get email or text messages about your prescription status, set up or change your prescription notifications.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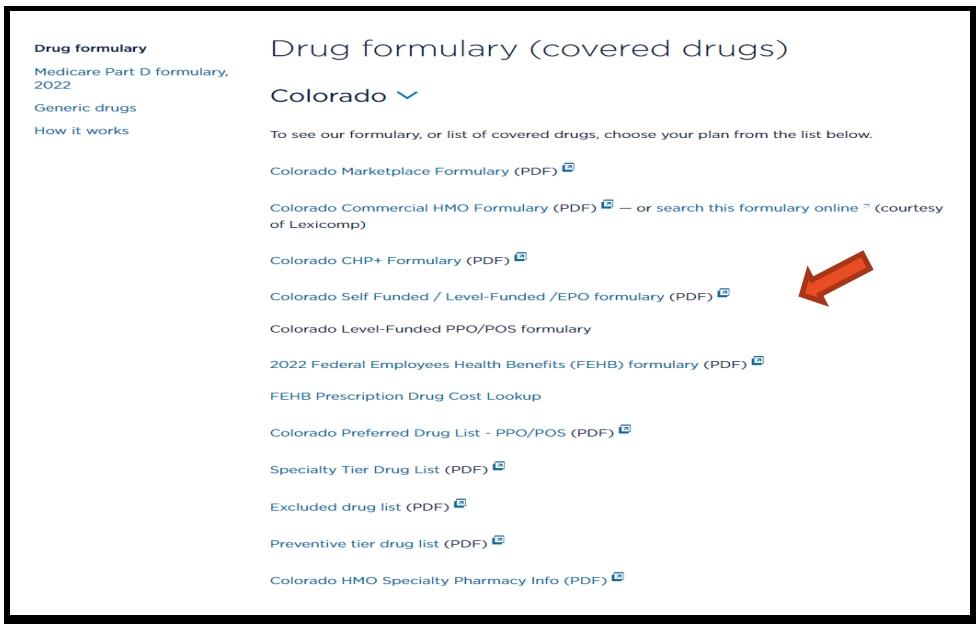
Search
My Health
Medical Record
Message Center
Appointments
Pharmacy
Coverage & Costs
Health & Wellness
Doctors & Locations
Drugs and natural medicines
Formulary (covered drugs)
About our formulary
Covered drugs in your area
Medicare Part D formulary, 2018
What is a formulary?
Our formulary is a list of drugs that have been approved for members by our Kaiser Permanente Pharmacy and Therapeutics Committee.
Printer friendly
Your doctor and other clinicians use the formulary to help determine the safest, most effective drugs to prescribe for you.
Find out what drugs are covered in your area.
Reviewed by: Mark Groshek, MD, and David McWaters, PharmD, JD, May 2014
© 2014 Kaiser Permanente
Explore our drug formulary
drugs covered in your area
about generic drugs
how our formulary works
exceptions for non-covered drugs
Prescriptions made easy
Refill your prescriptions online and have them mailed to you.
Clinical trials
Learn about new treatments being studied at Kaiser Permanente and other research centers.



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 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 *[*https://sp-cloud.kp.org/sites/teams-npps/SitePages/Manufacturer%20Coupons.aspx*]*. 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.

Exclusions:

- If a Service is not covered under this Plan, any drugs or supplies needed about 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
- Contraceptive drugs including devices such as diaphragms and cervical caps and products including injectables, except for oral contraceptives and Mirena IUD which are covered for Medically Necessary non-contraception only
- Drugs used to enhance athletic performance

- 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, except for those items listed in the Schedule of Benefits and the Preventive Exams and Services section below
- Drugs for which there is an over-the-counter equivalent
- Drugs used in fertility treatment
- Drugs used in the treatment of Sexual Dysfunction
- Aid in dying drugs

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 following preventive services 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.

The Plan covers the following preventive Services without a Copayment, Coinsurance, or Deductible, when these Services are delivered by a Network provider.

* KPIC complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability or sex. Age, Sex and Frequency guidelines will be determined by KP providers.
Preventive Services for adults
Abdominal aortic aneurysm—one-time screening by ultrasonography in men age 65 to 75 who have ever smoked*
Age-appropriate preventive medical examination
Annual lung cancer screening with low-dose computed tomography and counseling in adults 55 to 80 who are at high risk based on their current or past smoking history
Blood pressure screening
Colon cancer screening for adults age 45 to 75, including bowel preparations medications prescribed prior to a screening colonoscopy, pathology exam on a polyp biopsy, performed in connection with colon cancer screening, and pre consultation visit associated with colon cancer screening.
Depression screening
Diabetes screening (type 2) for adults with abnormal blood glucose
Discussion with primary care physician about alcohol misuse screening and counseling
Discussion with primary care physician about diet if at higher risk for chronic disease
Discussion with primary care physician about low-dose aspirin if at high risk of cardiovascular disease or colorectal cancer
Discussion with primary care physician about obesity and weight management, including intensive behavioral counseling for overweight adults at risk of cardiovascular disease
Discussion with primary care physician about sexually transmitted infections prevention
Discussion with primary care physician about tobacco use cessation and counseling
FDA-approved medications for tobacco cessation, including over-the-counter medications, when prescribed by a Plan provider
FDA-approved preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons at high risk of HIV acquisition, (when prescribed by a Plan provider), including the following baseline and monitoring services for the use of PrEP: - HIV testing - Hepatitis B and C testing - Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) - Pregnancy testing - Sexually transmitted infection (STI) screening and counseling - Adherence counseling
Hemoglobin A1C testing for the chronic condition of diabetes
Hepatitis B screening for adults at higher risk
Hepatitis C screening for adults 18 to 79 years
Immunizations for adults (doses, recommended ages, and recommended populations vary): - Hepatitis A - Hepatitis B - Herpes zoster - Human papillomavirus - Influenza - Measles, mumps, rubella - Meningococcal (meningitis) - Pneumococcal - Tetanus, diphtheria, pertussis - Varicella

International normalized (INR) testing for the chronic condition of liver disease and/or bleeding disorders
Low-density lipoprotein (LDL) testing for the chronic condition of heart disease
Latent tuberculosis infection screening
Over-the-counter drugs when prescribed by your doctor for preventive purposes: - Low-dose aspirin to prevent colorectal cancer - Low-dose aspirin to reduce the risk of heart attack
Physical therapy to prevent falls in community-dwelling adults age 65 and older who are at increased risk of falling *
Retinopathy screening for the chronic condition of diabetes
Routine Physical exam
Sexually transmitted infection screening for adults at higher risk: - Chlamydia - Gonorrhea - HIV - Syphilis
Statins use for the primary prevention of cardiovascular disease in adults age 40 to 75 years with no history of cardiovascular disease (CVD), one or more CVD risk factors and a calculated 10-year CVD event risk of 10% or greater
Unhealthy drug use screening in adults 18 or older
Universal lipids screening in adults 40 to 75 years to identify dyslipidemia and a calculation of a 10-year CVD risk
Preventive Services for women, including pregnant women*
Anemia screening for pregnant women
Anxiety screening for adolescent and adult women
Behavioral counseling for healthy weight gain in pregnant women
BRCA genetic counseling to assess risk of carrying breast/ovarian cancer genes (for those who meet U.S. Preventive Services Task Force guidelines)
BRCA genetic testing for high-risk women and when services are ordered by a Plan physician
Breastfeeding equipment
Cancer screening: - Breast cancer (mammography for women 40 and older) - Cervical cancer (for women 21 to 65)
Contraceptive devices, methods and drugs (FDA-approved and prescribed by your doctor), contraceptive device removal and female sterilizations
Counseling intervention for pregnant or postpartum persons at increased risk of perinatal depression
Discussion with primary care physician about Breastfeeding and comprehensive lactation support
Discussion with primary care physician about Chemoprevention for breast cancer if at higher risk
Discussion with primary care physician about Contraceptive methods
Discussion with primary care physician about Family history of breast and/or ovarian cancer
Discussion with primary care physician about Folic acid supplements (a daily supplement of 0.4 to 0.8 milligrams of folic acid if you are capable or planning pregnancy)
Discussion with primary care physician about Interpersonal and domestic violence
Discussion with primary care physician about preconception care
Discussion with primary care physician about tobacco cessation for pregnant women
FDA-approved medications for tobacco cessation for pregnant women, including over-the-counter medications, when prescribed by a Plan provider
Gestational diabetes screening for pregnant women at high risk or women between 24 and 28 weeks pregnant
Hepatitis B screening for pregnant women at their first prenatal visit
HIV screening for pregnant women
Low-dose aspirin after 12 weeks of gestation in women who are at high risk for preeclampsia
Osteoporosis screening for women 65 and older, and those at higher risk

Over-the-counter folic acid (a daily supplement of 0.4 to 0.8 milligrams of folic acid for women who are capable or planning pregnancy to reduce the risk of birth defects when prescribed by a doctor for preventive purposes)
Preeclampsia screening for pregnant women with blood pressure measurements during pregnancy
Prescribed, FDA-approved medications for breast cancer prevention if at higher risk, 35 and older with no prior history of breast cancer
Rh incompatibility screening (for pregnant women) and follow-up testing (for those at higher risk)
Routine Physical exam
Routine prenatal care visits
Screening for diabetes mellitus after pregnancy
Screening for urinary incontinence in women
Syphilis screening for all pregnant women
Urinary tract or other infection screening for pregnant women
Preventive Services for children
Age-appropriate preventive medical examination
Autism screening by primary care physician 18 months and 24 months *
Behavioral assessments by primary care provider throughout development
Blood pressure screening for adolescents
Cervical dysplasia screening for sexually active females*
Congenital hypothyroidism screening for newborns
Depression screening for adolescents 12 to 18 years
Developmental screening (under 3 years) and surveillance (throughout childhood) by primary care physician
Discussion with primary care physician about Alcohol and drug use counseling for adolescents
Discussion with primary care physician about Fluoride supplements for children who have no fluoride in their water source
Discussion with primary care physician about on supplements for children ~~age~~ 6 months to 12 months who are at risk for anemia *
Discussion with primary care physician about obesity screening and counseling
Discussion with primary care physician about Sexually transmitted infection prevention counseling for adolescents at higher risk
Discussion with primary care physician about Skin cancer counseling for young adults, adolescents, children and parents of young children about minimizing exposure to ultraviolet (UV) radiation for person 6 months to 24 years with fair skin types to reduce their risk of skin cancer
Discussion with primary care provider about tobacco use cessation and counseling
Dyslipidemia screening for children at higher risk of lipid disorders
FDA-approved medications for tobacco cessation, including over-the-counter medications, when prescribed by a Plan provider
Gonorrhea prevention medication for the eyes of newborns
Hearing screening for newborns
Height, weight, and body mass index (BMI) measurements throughout development
Hematocrit or hemoglobin screening
Hemoglobinopathies or sickle cell screening for newborns
Hepatitis B screening for adolescents at higher risk
HIV screening for adolescents at higher risk
Immunizations from birth to 18 years (doses, recommended ages, and recommended populations vary): - Diphtheria, tetanus, pertussis - *Hemophilus influenzae* type B - Hepatitis A - Hepatitis B - Human papillomavirus - Inactivated poliovirus - Influenza

- Measles, mumps, rubella - Meningococcal (meningitis) - Pneumococcal - Rotavirus - Varicella
Lead screening for children at risk of exposure
Medical history throughout development
Oral health risk assessment by primary care physician - Fluoride supplementation starting at 6 months for children who have no fluoride in their water source - Fluoride varnish for the primary teeth of all infants and children starting at the age of primary tooth eruption
Over-the-counter drugs when prescribed by a physician for preventive purposes: - Iron supplements for children to reduce the risk of anemia - Oral fluoride for children to reduce the risk of tooth decay
Phenylketonuria (PKU) screening in newborns
Routine physical exam
Tuberculin testing for children at higher risk of tuberculosis
Vision screening
Additional Preventive Services
Colorado Regional Mandated Services (CO HB 19-1301)
Breast cancer screenings for all at-risk individuals regardless of age
Prostate Cancer Screening
Expanded Preventive Services, IRS Notice 2019-45
Hemoglobin A1c testing for the chronic condition of diabetes
International Normalized Ratio (INR) testing for the chronic condition of liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing for the chronic condition of heart disease
Retinopathy screening for the chronic condition of diabetes
Additional information about preventive Services
Preventive and other Services provided during the same visit
There are some additional things to keep in mind about coverage for mandated preventive Services that are provided along with other Services during the same visit. The following Cost Share rules apply when a mandated preventive Service is provided during an office visit: If the preventive Service is billed separately (or is tracked as individual encounter data separately) from the office visit, then Cost Sharing may apply to the office visit. If the preventive Service is **not** billed separately (or is not tracked as individual encounter data separately) from the office visit, then: o If the primary purpose of the office visit is the delivery of the preventive service, then no Cost Sharing may apply to the office visit. o If the primary purpose of the office visit is **not** the delivery of the preventive service, then Cost Sharing may apply to the office visit. Note: The Preventive List is subject to changes based on new Federal recommendations (and clinical interpretations) issued after the date of this document

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. For a complete list of current 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.

Please note, recommendations in effect for less than one year and contraceptive Services for Religious Employers or Eligible Organizations may not be applicable to your Plan.

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
- Travel 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;
- Will correct significant disfigurement resulting from an injury, illness or congenital defects or Medically Necessary surgery;
- Following Medically Necessary removal of all or part of a breast, reconstruction of the breast as well as surgery and reconstruction of the other breast to produce a symmetrical appearance is covered.
- Correction of congenital hemangioma (known as port wine stain) is limited to hemangiomas of the face and neck for children aged 18 years and younger.

Exclusions:

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

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

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Habilitative services are therapeutic services that are provided to children with congenital conditions (present from birth), and developmental delays to enhance

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

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

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

Exclusions:

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

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 preauthorization:

  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 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.

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 the purpose of 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
  - **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

- Above waist –
  - **Assigned at birth male** - lipoplasty of the waist, face lifts, blepharoplasty, collagen injections, gender confirming facial reconstruction) 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 after-hours care.

In the Service Area

Urgent Care Services are covered and may be provided in your doctor's office after office hours or a Network urgent care facility. If you think you may need urgent care, call the advice nurse telephone number for help. (See the "Customer Service Phone Numbers" section or www.kp.org).

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.

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 particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Abortions: Voluntary, elective abortions and any associated Services, drugs or supplies are specifically excluded, with the exception of treatment of complications following an abortion.
Before coverage begins - Any Services, drugs, or supplies you receive while you are not enrolled in this Plan
Behavioral/conduct problems - Any educational Services and programs or therapies for behavioral/conduct problems. This exclusion does not apply to coverage for medication management.
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
Contraceptives dispensed during an office visit: Counseling, provision and administration of contraceptives, except Mirena IUD when Medically Necessary **Contraceptives not covered by SCL**. Check with KPIC regarding payment for those services.
Cosmetic Services - Except for Medically Necessary reconstructive surgery and related services.
Custodial Care - Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to Services covered under "Hospice Care"
Dental Services not listed elsewhere in your coverage. This exclusion also applies to accidental injury to sound and natural teeth.
Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders)
Education - Services other than Health Education or Self-Management of a medical condition as determined by the KPIC to be primarily educational in nature.
Excluded Providers: Services, supplies, equipment or prescriptions provided by OIG (Office of the Inspector General) excluded providers.

Experimental or investigational Services Kaiser Permanente, determines that a Service is experimental and investigational when: - Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients); - It requires government approval that has not been obtained when Service is to be provided; - It cannot be legally performed or marketed in the United States without FDA approval; - It is the subject of a current new drug or device application on file with the FDA; - It has not been approved or granted by the U.S. Food and Drug Administration (FDA) excluding off-label use of FDA approved drugs and devices - It is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; - It is subject to approval or review of an Institutional Review Board or other body that approves or reviews research; - It is provided pursuant to informed consent documents that describe the Services as experimental or investigational, or indicate that the Services are being evaluated for their safety, toxicity or efficacy; or - The prevailing opinion among experts is that use of the Services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the Service; - It is provided for Non-referred Services in connection to an approved clinical trial and/or Services in connection with a non-approved clinical trial; Services related to Clinical Trials are considered Experimental and Investigational when; - Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); - Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and - Items or Services needed for reasonable and necessary care arising from the provision of an investigational item or Service--in particular, for the diagnosis or treatment of complications.
Fertility Services and drugs - The following and related services to the further diagnosis and treatment of Infertility after initial diagnosis has been made: artificial insemination, and variations of these procedures, In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT); 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; and 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
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.
Hypnotherapy (Hypnosis)
Immunizations administered strictly for the purpose of travel outside of the United States, with the exception of vaccinations associated with COVID-19.
Legal Prohibition Charges prohibited by any law of the jurisdiction in which the Participant resides at the time the expense is incurred.

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
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 Combound products unless the frug is listed on our drug formulary or one of the ingredients requires a prescription by law Contraceptive Devices and products 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 Emergency Contraceptives 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 Fertility Drugs used in the treatment of Sexual Dysfunction End of Life Drugs
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 unless a Network Physician determines Medical Necessity.
Private Duty Nursing in home or long-term facility
Private room unless Medically Necessary or if a semi-private room is not available
Recreational, diversional and play activities
Religious, personal growth counseling or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling unless the primary patient has a mental health diagnosis.
Services, drugs, or supplies if not Medically Necessary
Services billed more than 365 days after the date of service or dispensing.

Services for conditions that a Network Physician determines are not responsive to therapeutic treatment.
Services provided outside the United States - Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States
Services related to a non-Covered Service- All Services, drugs, or supplies related to the non-Covered Service are excluded from coverage, except Services we would otherwise cover for the treatment of complications and rehabilitation of the non-Covered Service
Services that Are the Subject of a non-Network Provider's Notice and Consent Amounts owed to non-Network Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable federal law.
Sexual Dysfunction - Any Services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
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 covered as a dependent.
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.
Gender Affirming related services listed below: Cosmetic Surgery Sperm procurement and storage in anticipation of future Fertility unless covered under Fertility Services benefit Gamete preservation and storage in anticipation of future Fertility unless covered under Fertility Services benefit Cryopreservation of fertilized embryos in anticipation of future Fertility unless covered under Fertility Services Other electrolysis or laser hair removal not specified as covered Vaniqa
Travel or transportation expenses (other than transportation covered under the Plan) even though prescribed by a Network Physician or non-Network Physician except as noted under Transplants and Gender Affirming Surgery
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.
Vision- Hardware (eyeglasses, lenses, contact lenses) as prescribed to correct visual acuity
Waived fees - Free Services (no charge items)

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 worker's compensation law.

General Limitations

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

Coordination of Benefits

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

When Coordination of Benefits Applies

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

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

Definitions

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

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

- Coverage Plan includes: group and non-group insurance, health maintenance organization (HMO) contracts, closed panel or other forms of group or group type coverage (whether insured or uninsured); medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- Coverage Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage, as defined by state law; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other federal governmental plans, unless permitted by law.

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

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

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

"**Allowable Expense**" means a health care expense, including deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of Services (for example an HMO), the reasonable cash value of each Service will be considered an Allowable Expense and a benefit paid. An expense or an expense for a Service that is not covered by any of the Coverage Plans is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered

person is not an Allowable Expense. The following are additional examples of expenses or Services that are not Allowable Expenses:

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

"Claim Determination Period" means a 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 Coverage Plan reduces its Benefits as described below for covered persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

- The person is eligible for, but not enrolled in, Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B. To determine when Medicare is primary see the excerpt from https://www.medicare.gov/Pubs/pdf/02179.pdf

If you	Situation	Pays first	Pays second
Are covered by Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage (like employer group health plans) has paid
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare	Group health plan	Medicare
	The employer has 20 or more employees		
	The employer has less than 20 employees*	Medicare	Group health plan
Have an employer group health plan through your own former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, domestic partner, son, daughter or grandchild) who is working	Entitled to Medicare	Large group health plan	Medicare
	The employer has 100 or more employees		
	The employer has less than 100 employees	Medicare	Group health plan
**Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Have ESRD and COBRA coverage	First 30 months of eligibility or entitlement to Medicare on the basis of ESRD	COBRA	Medicare
	After 30 months	Medicare	COBRA

If you	Situation	Pays first	Pays second
Are 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services related to accident claim	Medicare
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment (a payment that must be repaid to Medicare when a settlement, judgment, award, or other payment is made.)
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare- covered services. Veterans' Affairs pays for VA-authorized services. **Note:** Generally, Medicare and VA can't pay for the same service.	Usually doesn't apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare- covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	The Federal Black Lung Benefits Program for services related to black lung.	Medicare

* If your employer participates in a plan that's sponsored by 2 or more employers, the rules are slightly different.

** If you originally got Medicare due to your age or a disability other than ESRD, and Medicare was your primary payer, it still pays first when you become eligible due to 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 in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, this first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, 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, whether you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its’ option, take necessary and appropriate action to preserve its’ rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate’s name, which does not obligate us in any way to pay you part of any recovery The Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the 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 in order 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 in connection with that arrangement ("Surrogacy Health Services"), except that the amount You must pay will not exceed the payments or other compensation You and any other payee are entitled to receive under the Surrogacy Arrangement. A Surrogacy Arrangement is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Copayments and or Coinsurance for these Services, you will be credited any such payments toward the amount you must reimburse the Plan us under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

Within 30 days after entering a Surrogacy Arrangement, you must send written notice of the arrangement, 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

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 our liens and other rights.

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

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

- From any source providing a Financial Benefit or from whom a Financial Benefit is due

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

Dispute Resolution

Grievances

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 through www.kp.org, and a Customer Service 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.

As a result of the national emergency related to the COVID-19 outbreak, the time periods in which you may file a claim and file a request for an appeal of a denied claim have been extended to the extent required by law. Generally, you have up to 60 days after the announced end of the national emergency related to the COVID-19 outbreak to file a claim or request an appeal of a denied claim.

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.

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 the Plan. 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, whichever 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 claim's payment decision, you must follow the procedures outlined in this "Claims and Appeals" section.

If you miss a deadline for filing a claim or appeal, review may be declined. Before you can file a civil action under ERISA section 502(a)(1)(B), you must meet any deadlines and exhaust the claims and appeals procedures set forth in this "Claims and Appeals" section. There is no charge 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 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 of 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 then go to *My Health Manager* then *My Plan and Coverage,* then select the bullet *Claims Summary*. The claim form will inform you about other information that you must include with your 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 within the time frames in the chart below. 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) state the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.
- The notice will also state how and when to request a review of the denied claim.
- If applicable, the notice will also contain a statement of your right to bring a civil action under Section 502(a) of ERISA of an adverse benefit determination following completion of all levels of review.

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 a request, you should 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:

Colorado
Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042

For Post Service Denials send your written appeal to:

KPIC Appeals PO BOX 939001 San Diego, CA 92193 800-464-4000

Or for Urgent appeals submitted over the phone call

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

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

In addition, under 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 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.

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

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

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 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 the Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other

information (other than legally or medically privileged documents) relevant to your claim.

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) 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 the information about those procedures.
- The notice will also include a statement of your right to bring an action under section 502(a) of ERISA 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:

Colorado
Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042

For Post Service Denials send your written appeal to:

KPIC Appeals PO BOX 939001 San Diego, CA 92193 800-464-4000

Or for Urgent appeals submitted over the phone call

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

Timing of Final Appeal Determinations

For Pre-Service Claims and Post-Service Claims, 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

under section 502(a) of ERISA 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, you may request an independent External Review as described below.

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

External Review

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

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

To request an independent external review of Plan denials, complete the External Review request form on www.kp.org and send the written request to:

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:

Colorado
Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042

For Post Service Denials send your written appeal to:

KPIC Appeals PO BOX 939001 San Diego, CA 92193 800-464-4000

Or for Urgent appeals submitted over the phone call

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

Preliminary Review of External Review Request

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

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

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

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

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

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

Referral To Independent Review Organization

KPIC will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally recognized accrediting organization to conduct the external review. Moreover, KPIC will act to guard against bias and to ensure independence. Accordingly, KPIC will maintain contracts with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO 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 State or Federal law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and

- Current contact information, including phone number, for any applicable ombudsman established under the PHS Act of 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, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant or its eligibility determination.

Referral To Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements

set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, 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

The Plan'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 in paragraph A.3 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. You may file a civil action under section 502(a) of the federal ERISA statute. You must commence any legal or equitable action for benefits within one year after the date that notification is sent to the participant or beneficiary (and/or his or her authorized representative) that the adverse benefit determination has been upheld on appeal.

Termination

Termination Due to Loss of Eligibility

If you are an Associate, your coverage under the Plan will cease on the earliest date below:

- the last day of the month in which you cease to be an eligible Associate or cease to qualify for the coverage.
- the last day for which you have made any required contributions for coverage.
- the effective date of your election not to participate in the Plan.
- the date the Plan is amended in a manner which results in you ceasing to be eligible for coverage.
- the date your employer ceases to be a participating employer in the Plan.
- the date the Plan is terminated.
- at the end of any applicable Stability Period unless you are eligible for coverage for the following Stability Period.

Coverage for your Dependents will cease on the earliest date below:

- the date your coverage ceases.
- for an individual Dependent, the last day of the month in which the individual ceases to be a Dependent.
- the last day for which you have made any required contributions for coverage.
- the effective date of your election not to cover your Dependents under the Plan.
- the date the Plan is amended in a manner which results in you ceasing to be eligible for coverage.
- the date the Plan is terminated.

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 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 misuses 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

This summary explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. .

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children 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.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Eligible Associate dies;
- The parent-Eligible Associate's hours of employment are reduced;
- The parent-Eligible Associate's employment ends for any reason other than his or her gross misconduct;
- The parent-Eligible Associate becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an "Eligible Dependent."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the associate; or
- The associate's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the associate and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to:

SCL Health
HR Service Center
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

Notice forms may be obtained by calling the Human Resources Department at (855) 412-3701 or online at so-hrsupport@sclhealth.org. If you do not provide notice within the time period above or if you do not provide any additional documentation or information (if requested) in a timely manner, your notice will be rejected and COBRA coverage will not be offered.

Note: As a result of the national emergency related to the COVID-19 outbreak, the time period you have to notify the Plan Administrator of a qualifying event has been extended to the extent required by law. Generally, you have up to 60 days after the announced end of the national emergency related to the COVID-19 outbreak to provide this notification.

How is COBRA continuation coverage provided?

Once the Plan 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 employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum 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 COBRA continuation coverage. Notice must be provided in writing to:

WEX, Inc.
P.O. Box 869
Fargo, ND 58107-0869
Phone: (866) 451-3399
Fax: (888) 408-7224
Ask a question: cobraadmin@wexhealth.com
Submit a form: cobraforms@wexhealth.com

If the above notification is not timely made, or if you do not provide the additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA/continuation coverage beyond the original 18-month period will not be offered.

The affected individual must also notify the Discovery Benefits, Inc. within 30 days of any final determination by the Social Security Administration that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the associate or former associate dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

SCL Health
500 Eldorado Blvd., Ste. 4200
Broomfield, CO 80021

SCL Health Human Resources Department may be reached by phone at (855) 412-3701.

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 will be timely notified of such termination and their 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 after receipt of the notice or until theyyou are no longer a Continuing Care Patient.

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

Miscellaneous Provisions

Overpayment Recovery

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

Qualified Medical Child Support Order

The Plan will provide coverage as required by any qualified medical child support order ("QMCSO"), as defined in ERISA §609(a). 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.

ERISA Notices

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act of 1998

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

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

The Plan covers mastectomies and related Services, subject to all provisions of this Plan document, such as the provisions concerning exclusions, Copayments, and Coinsurance.

Statement of ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

  Send written requests to:

  HR Benefits Department
  500 Eldorado Blvd., Suite 4600
  Broomfield, CO 80021

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person,

may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about the rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Legal and Administrative Information

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

Plan Name:	SCL Health Medical Plan The Plan is part of the SCL Health Associate Health Benefit Plan
Plan Sponsor and ERISA Plan Administrator:	SCL Health 500 Eldorado Blvd. Ste. 4300 Broomfield, CO 80021 303-813-5250

An individual has been designated as the Plan's administrative fiduciary. The administrative fiduciary is responsible for certain aspects of the Plan's administration. In that capacity, the administrative fiduciary has full discretion and authority to determine eligibility, control and manage the Plan, interpret the provisions of the Plan, and determine benefits payable under the Plan.

Plan Sponsor EIN:	23-7379161
Plan No.:	521

Participating Employers:

- SCL Health-Front Range, Inc.
- SCL Health Medical Group - Denver, LLC
- Brighton Community Hospital Association (d/b/a Platte Valley Medical Center)
- Platte Valley Medical Group, LLC
- SCL Front Range Home Health, LLC

Plan Year:	January 1 - December 31
Type of Plan:	Employee welfare benefit plan providing medical benefits
Claims Administrator:	Kaiser Permanente Insurance Company
Claims Fiduciary:	Harrington Health

Funding Medium:	Contributions to the Plan are made by both the Associates and the Employers. Benefits from the Plan are paid from the Employer's general assets. Kaiser does not insure any benefits under the Plan.
Service of Legal Process:	SCL Health c/o Senior Vice President, Chief Human Resources Officer 500 Eldorado Blvd, Suite 4300 Broomfield, CO 80021

Amendment/Termination of the Plan:

The Plan Sponsor reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all of the provisions of the Plan, and may terminate the Plan, as follows:

(a) The Board of Directors of the Plan Sponsor, in its sole discretion, may amend or modify the Plan, in whole or in part, at any time, and may terminate the Plan at any time.

(b) The President/Chief Executive Officer of the Plan Sponsor, in his or her sole discretion, may amend or modify the Plan to the extent such amendment or modification would not constitute a material change in the benefits design or philosophy of the Plan Sponsor or result in a material increase in costs to the Sponsoring Employer. In determining whether an amendment constitutes a material change or would result in a material cost increase for this purpose, the determination of the President/Chief Executive Officer will be binding on the Plan Sponsor and the Plan.

(c) The Senior Vice President, Chief Human Resources Officer, of the Plan Sponsor, or the person from time to time performing such function, may amend or modify the Plan at any time to the extent such amendment or modification is routine, required by law or where circumstances make it impracticable for action by the President/Chief Executive Officer of the Plan Sponsor.

No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered medical expenses incurred prior to the date the Plan terminates.

Service Areas

Participants must live or work in the Colorado Kaiser Service Area at the time of enrollment. You cannot continue enrollment as a Participant if you move outside or stop working within the Colorado 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

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

Utilization Management for Out-of Network Emergency Services

Northern California Region	800-225-8883
Southern California Region	800-225-8883
Colorado Region	303-338-3800
Mid-Atlantic States Region	800-810-4766
Northwest Region	866-813-2437
Georgia Region	800-221-2412

Advice Nurses

Northern California Region	866-454-8855
Southern California Region	888-576-6225
Colorado Region	866-311-4464
Mid-Atlantic States Region	703-359-7878
(Outside Washington Metro Area)	800-777-7904
Northwest Region	503 813-2000
Outside Portland	800 813-2000
Georgia Region	800-611-1811

Interpreter Services

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

TTY 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

HRA Administrator:

Kaiser Permanente HRA
Health Payment Services
C/O HAS
PO Box: 1540
Fargo, ND
58107-1540

Pharmacy Claim Form

OPTUMRx®

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member Information

RxGroup *(see ID card)* | Member ID *(see ID card)*

Last Name | First Name | MI

Mailing Street Address | Apt. #

City | State | ZIP

Prescription is for ○ Self ○ Spouse ○ Dependent | Gender ○ M ○ F

Date of Birth *(mm/dd/yyyy)* ___/___/_____

2 Physician and Pharmacy Information

Prescribing Physician Name | Dispensing Pharmacy Name

Prescribing Physician Phone Number with Area Code | Dispensing Pharmacy Phone Number with Area Code

3 Reason For Request

Select appropriate options for your request:

- ○ I did not use my Prescription Drug ID card
- ○ I used a non-participating pharmacy *(please explain)* _____
- ○ I filled a compound prescription *(your pharmacist must complete section B on the back of this form)*
- ○ I purchased medication outside of the United States
  Country _____ Currency used _____
- ○ My primary coverage is with another insurance carrier *(coordination of benefits claim; see section C on back for details)*
  - ○ I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  - ○ I am submitting a copay receipt
- ○ I was waiting for a drug approval
- ○ I was retroactively enrolled with the plan
- ○ My pharmacy billed the wrong plan
- ○ Other *(please explain)* _____

4 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____

ORX5262-KPI_130909

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.

104-0012 6/13 ORX5262_130518 PEX6710-005 UHCEX613968_000

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 MO | DY | YR	THROUGH 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 PRINTED NAME:_____CREDENTIALS____ SIGNED:_____DATE:_____					PROVIDER BILLING NAME, ADDRESS, ZIP CODE AND PHONE#		

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:

Bǎsɔ̀ɔ̀ - 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 ɓéɗé bá kpáná ɓě m̀ kɔ̃ m̀ ké dyéɛ jè dyí, mɔɔ ɔ jŭ ké wa dyi níin m̀ mɛ nyu dɛ dɛ́é ɓě bó wé jɛ̀é dɔ̀ kɔ̃ɛɛ ní, nìí, m̀ mɛ dá nɔ̀bà ɓɛ́ wa tòà bó nì bóɗɔ́ɔ mɔɔ bó nì gbɛ̃ɛ̀ɔ̀ bìiɛ, ɓɛ́ m̀ ké nyɔ-wuɗuún-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.

ลาว (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັງຄ່າ. ຖ້າວ່າ ທ່ານມີຄຳຖາມກ່ຽວກັບຜົນປະໂຫຍດຂອງທ່ານ, ຫຼື ທ່ານຈຳເປັນຕ້ອງດຳເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສຳລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລົມກັບນາຍພາສາ.

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

Naabeehó (Navajo): Doo bik'é asínílǫ́ągo 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): तपाईंले कुनै खर्च बिना आफ्नो भाषामा सहायता पाउने अधिकार छ। यदि सुविधाहरूका बारेमा तपाईंको कुनै प्रश्नहरू भए, अथवा कुनै निर्धारित मिति भित्र तपाईंले कुनै कारवाही गर्न आवश्यक भए, कुनै दोभाषेसँग कुरा गर्न तपाईंको 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 ਫ਼ਾਇਦਿਆਂ 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 gaoioi 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 ètọ́ láti gba ìrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Tí o bá ní ibéèrè nípa àwọn ànfàní rẹ tàbí o ní láti gbé ìgbésẹ̀ kan ní ọjọ́ kan pàtó, pe nọ́mbà tí a pèsè fún ìpínlẹ̀ rẹ tàbí agbègbè láti bá òṣìṣẹ́ kan sọ̀rọ̀.

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