

Benefit Booklet for
Reta Plan
Coverage Option: EPO
July 2026 - June 2027

Administered by:

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

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Introduction

About the Reta Plan and the Reta Trust

The Reta Plan is not an insured benefit plan. Benefits are funded by the Reta Trust, not an insurance company. This means that the Reta Trust is responsible for the payment of benefits available under the Reta Plan. Kaiser Permanente Insurance Company provides only administrative services for several of the coverage options under the Reta Plan on behalf of the Reta Trust and does not insure the Plan's benefits.

The Reta Trust was established in 1976 by Roman Catholic dioceses and religious orders to provide health care plans for clergy, religious members, and employees and eligible family members of Catholic employers. The Catholic entities and employers who choose to participate in the Reta Trust are sometimes referred to as "Reta Trustors."

The Reta Plan and its constituent group health plan coverages adhere to the Ethical and Religious Directives for Catholic Health Care Services, as modified from time to time ("Ethical and Religious Directives"). The Reta Plan only provides benefits that are consistent with these Ethical and Religious Directives. For your reference, the Seventh Edition of the Ethical and Religious Directives published in 2025 can be found at the following webpage:

https://www.usccb.org/resources/ethical-and-religious-directives-catholic-health-care-services-seventh-edition

Even if you are not Catholic, or if your personal beliefs are inconsistent with the Ethical and Religious Directives, the Reta Trust can only provide you with Services that are consistent with the Ethical and Religious Directives. The Reta Trust has delineated those Services within this Benefit Booklet. There are no exceptions. Catholic healthcare institutions are also bound by these Ethical and Religious Directives and will be unable to perform procedures or provide medicines or Services that are contrary to the Ethical and Religious Directives. This Benefit Booklet may contain statements that you might interpret as inconsistent with the Ethical and Religious Directives; however, Services that are contrary to the Ethical and Religious Directives are specifically excluded from coverage.

The Reta Plan is not an insured health care plan. Kaiser Permanente Insurance Company (KPIC) provides claims administration services for the coverage option that is described in this Benefit Booklet. KPIC is not an insurer of the Reta Plan or financially liable for the Plan's benefits. In that role, it is the "Claims Administrator."

The Reta Trust is the "Plan Sponsor" and also the "Plan Administrator." As such, the Reta Trust provides funding for benefit claims and retains exclusive and ultimate responsibility for its administration. In this Benefit Booklet, Plan Participants and enrolled dependents are sometimes referred to as "you" and "your."

About this Booklet

This Benefit Booklet is one of the documents under which the Reta Plan is governed and operated. Another document under which the Reta Plan is governed and operated is the Plan Constitution.

This Benefit Booklet is a description of the Benefits available under the group health plan coverage option under the Reta Plan that is administered by Kaiser Permanente Insurance Company, which is described as an "exclusive provider organization" or "EPO." The Cost Sharing details for the coverage option are set forth in the "Schedule of Benefits" section at the end of this booklet. In this booklet, the term "Plan" will refer either to this group health plan coverage option or the Reta Plan as called for by the context.

Many terms used in this Benefit Booklet have specific definitions. These definitions can be found either in the specific applicable section of this Benefit Booklet or in the section of this Benefit Booklet entitled "Definitions." Most of the terms that are capitalized throughout this Benefit Booklet have definitions set forth in that section.

A separate document, the Summary Plan Description for the Reta Plan, contains important information about your eligibility for coverage, when your coverage starts and ends, and many of your legal rights. You should make sure you have a copy of the Summary Plan Description. Contact your Employer for information as to how to obtain a copy of the Summary Plan Description.

The Reta Trust reserves the right to amend, reduce, suspend or terminate any of the terms of this Benefit Booklet at any time. In the case of a change to this Benefit Booklet that is a material reduction in covered services or benefits, a notice of such material reduction shall be provided to Participants not later than 60 days after the date on which such material reduction is effective.

About this Coverage Option

The group health plan coverage option described in this Benefit Booklet is an Exclusive Provider Organization (EPO) plan. What this means is that you must receive all Covered Services from Network Providers, with this very important exception: You can receive covered Emergency Services, Post-Stabilization Services, 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.

As mentioned earlier, the Cost Sharing details for this coverage option are set forth in the "Schedule of Benefits" section at the end of this Benefit Booklet.

When you enroll in a coverage option described in this Benefit Booklet, your care will be provided in one of the following Kaiser Permanente Regions: Northern California, Southern California and Northwest. Each Region has its own Service Area, but you can receive Covered Services in any Region's Service Area.

You are enrolled in a specific group health plan coverage option offered by your Employer. The Covered Services, Cost Sharing, and limitations that are specific to your benefit coverage are described in the Schedule of Benefits that is found at the end of this Benefit Booklet. The Schedule of Benefits is a part of this Benefit Booklet, but does not describe all the details of your Benefits. For more information on specific Benefits, please refer to the applicable Benefit in the "Benefits and Cost Sharing" section. See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section.

Customer Service Phone Numbers

General Customer Service

Northern California Region	800-663-1771
Southern California Region	800-533-1833
Northwest Region	866-800-3402

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
Northwest Region	866-813-2437

Advice Nurses

Northern California Region	866-454-8855
Southern California Region	888-576-6225
Northwest Region	503 813-2000
Outside Portland	800 813-2000

Interpreter Services

Northern California Region	800-663-1771
Southern California Region	800-533-1833
Northwest Region	866-800-3402

TTY

All Regions 771 or 877-870-0283

COBRA Administrator

Benefit Allocation Systems 888-887-6187
P.O. Box 62407
King of Prussia, PA 19406

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

Definitions

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

The following terms, when capitalized and used in any part of this Benefit Booklet, have the meanings set forth below:

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary's, eligibility to participate in the Plan.
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or Service for which benefits are otherwise provided because such item or Service is determined to be experimental or investigational or not Medically Necessary or appropriate.
- The Plan's determination as to whether the Plan is complying with the non-quantitative treatment limitation parity provision of the Mental Health Parity and Addiction Equity Act.
- Plan determinations that involve plan compliance with surprise billing and cost-sharing protections under the federal No Surprises Act.

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

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

Ancillary Service: Services that are:

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

Benefit Booklet: This booklet.

Benefits: Your right to payment for Covered Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Plan as stated in this Benefit Booklet and in the "Schedule of Benefits" section found at the end of this Benefit Booklet.

Claims Administrator: Kaiser Permanente Insurance Company (KPIC) is the Claims Administrator for the Reta Trust . You can find the addresses where you submit your medical and prescription drug claims in the "Customer Service Phone Numbers" section of this Benefit Booklet and on your ID card.

COBRA: The health care continuation coverage provisions of the federal 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 of this Benefit Booklet.

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

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

Cost Sharing: Copayments, Coinsurance, and Deductibles and any other amounts that you must pay for Covered Services except as otherwise provided herein.

Covered Person: A Participant or Dependent enrolled in the group health plan coverage described in this Benefit Booklet.

Covered Service: Services that meet the requirements described in this Benefit Booklet. To be a Covered Service, a Service must meet all of the following criteria: (1) meet the requirements for coverage as described in this Benefit Booklet including but not limited to Medical Necessity for your medical condition; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; and (4) be consistent with the Ethical and Religious Directives.

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "General Limitations, Coordination of Benefits, and Reductions" section.

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

- For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury; or
- To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision

over self-administration of medication not requiring the constant attention of trained medical personnel.

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

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

Deductible: A specific dollar amount you are required to pay for certain types of Covered Services during a Plan Year before Benefits will be paid. The Deductible is calculated after the Eligible charges are determined and prior to any Coinsurance or Copayment.

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

Dependent: A person who is eligible for coverage under the Plan on the basis of the person's relationship to the Participant. **Important information about the eligibility of children and spouses as Dependents is contained in the Summary Plan Description.** This Benefit Booklet sometimes refers to a Dependent or Participant as "You.".

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

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

Eligible Charges:

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

payment, the amount the Plan would have paid if it did not subtract Cost Sharing.

- For Emergency Services and scheduled Covered Services at a Network Hospital or ambulatory surgical center rendered by Non-Network Providers, the amount owed pursuant to federal law.
- For all other Covered Services provided by Non-Network Providers, the amount to which the Non-Network Provider agrees to accept for such Covered Services.
- Cost sharing will be calculated based on the Eligible Charges for such Covered Services.

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

- Placing the person's health (or, with respect to a pregnant woman, the health of the pregnant woman or 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 herself or himself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

- A medical screening examination (as required under the federal Emergency Medical Treatment and Labor Act (EMTALA)) and stabilization Services that are within the capability of the emergency department of a hospital or Independent Freestanding Emergency Department, including professional and ancillary Services routinely available to the emergency department to evaluate and Stabilize the Emergency Medical Condition.
- Post Stabilization Services and outpatient observation during the same visit until the attending emergency physician or treating provider/facility: (1) determines you may travel using nonmedical transportation or nonemergency medical transportation; and (2) has obtained informed consent from you for such items/Services pursuant to applicable law. When you (or your authorized representative) consent to the provision of Services by a Non-Network Provider, then the plan will not cover 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).

Employer: The employer of a Participant, which is a Trustor of the Reta Trust or a constituent employer of a Trustor. For a Participant who is a member of the clergy or a religious member, the Trustor providing for the Participant's enrollment is also referred to, for ease of description, as "Employer."

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).

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

Ethical and Religious Directives: The "Ethical and Religious Directives for Catholic Health Care Services" published by the United States Conference of Catholic Bishops as amended from time to time. The Ethical and Religious Directives have two purposes: (1) "to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person" and (2) "to provide authoritative guidance on certain moral issues that face Catholic health care today." A complete statement of the Seventh Edition of the Ethical and Religious Directives published in 2025 can be found at the following webpage:

https://www.usccb.org/resources/ethical-and-religious-directives-catholic-health-care-services-seventh-edition

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

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

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

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

the information described below and assess whether:

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

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

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

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

Family: A Participant and his or her 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.

Infertility: (1) the presence of a medical or other demonstrated condition that is recognized by a Plan Provider as a cause of Infertility; or (2) the inability to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

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

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

Note: The Reta Plan administered by Kaiser Permanente Insurance Company (KPIC) permits enrollment of Participants and Dependents who live or work in a Kaiser Permanente Region.

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

Medically Necessary and Medical Necessity: A Service is Medically Necessary and there is a Medical Necessity for the Service if, in the judgment of Kaiser Permanente, the Service 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.

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "General Limitations, Coordination of Benefits, and Reductions" section.

Medicare: A federal health insurance program for people aged 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 as described below. The list of Network Providers is subject to change at any time without notice. **For current locations of Network Providers please visit www.kp.org or call Customer Service at the number listed in the "Customer Service Phone Numbers" section.** To find a Kaiser Pharmacy visit www.kp.org – select *Pharmacy*.

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

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

Network 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, Marriage, Family, & Child Counselors (MFCCs), Licensed Social Clinical Social Workers (LCSWs), Optometrists, and Physical, Speech, and Occupational Therapists. Such providers will be subject to the primary care Cost Sharing but verify referral requirements in the "How to Obtain Health Care Services" section.

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

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

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

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

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

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

Out-of-Pocket Maximum: The maximum dollar amount you can be required to pay for certain Covered Services you receive annually. This amount includes Cost Sharing and Deductible amounts.

Participant: A person who is enrolled in the Plan as an employee, member of the clergy or religious member of an Employer, and who is eligible in their own right and not because of his or her relationship to someone else. This Benefit Booklet sometimes refers to either a Participant or Dependent as "you."

Plan: The Reta Plan and the coverage option described in this Benefit Booklet.

Plan Administrator: The Reta Trust.

Plan Sponsor: The Reta Trust.

Plan Year: July 1st through the following June 30th.

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

Necessary pursuant to a request for Prior Authorization for the Service.

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

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

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "General Limitations, Coordination of Benefits, and Reductions" section.

Procured Elective Abortion: Any deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth, whether chosen for its own sake or for a further end.

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

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

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

Self-Funded Medical Plan: Refers to an arrangement in which the employer or group of employers operating through a voluntary employees' beneficiary association (such as the Reta Trust) assumes the financial risk for providing health care benefits to enrolled employees and dependents. Instead of paying a fixed premium to an insurance carrier or HMO, health care claims are paid from the general assets of the employer or the voluntary employees' beneficiary association (such as the Reta Trust) as the claims are incurred. Claims are usually processed through a third party that acts as a claims administrator (such as Kaiser Permanente Insurance Company).

Schedule of Benefits: The schedule at the end of this Benefit Booklet that sets forth, Cost Sharing, Exclusions and limitations for the particular group health plan benefit plan coverage in which you are enrolled.

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

Service Area: One of the geographic areas listed at the back of this Benefit Booklet in which you must live or work at the time of enrollment. You cannot continue enrollment as a Participant in a coverage option of the Plan administered by KPIC if you move outside a Service Area.

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

Spouse: The husband or wife of a Participant under a legally valid marriage who meets the requirements for eligibility established by the Participant's Employer. For this Plan, Spouse does not include any person who is covered as a Participant.

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 them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant woman or unborn child), "Stabilize" means to deliver the child (including the placenta).

State of Emergency: During a national or regional state of emergency patient care may be handled in a variety of new and unusual locations (i.e., Drive up testing in parking lots, overflow inpatient care in convention centers, floating military hospitals and reopened previously closed facilities). Payment for Services rendered by licensed providers will be based on provider licensure rather than place of Service.

Summary Plan Description: An ERISA required document which conveys certain information about the Plan in an understandable summary.

Surprise Billing: Unexpected billing by a Non-Network Provider (except when you have consented) that is in excess of the cost-sharing amount for Services provided by a Network Provider in one or more of the following circumstances: (1) Emergency Services, (2) certain ancillary Services performed by a Non-Network Provider at a Network facility, or (3) air ambulance Services from a Non-Network Provider. When Surprise Billing occurs, you are only required to pay the cost-sharing amount for Services provided by a Network Provider.

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

Eligibility, Enrollment, and Effective Date

Plan Eligibility Requirements

Each Employer establishes the rules for the eligibility for coverage under the Plan of its employees as Participants and their Dependents. To be eligible for coverage as a Participant, you must meet all of your Employer's eligibility requirements and complete any waiting period established by your Employer. For any coverage option administered by KPIC, you must also meet the Service Area eligibility requirement (see below).

A Participant's natural and adopted children under the age of 26 may be enrolled in coverage under the Plan as your Dependents. Other categories of children (such as stepchildren and disabled children over age 26) may also be eligible for enrollment as your Dependents if they meet the Employer-specific eligibility requirements for coverage established by your Employer.

A Participant's Spouse may also be able to enroll in coverage under the Plan as your Dependent if he or she meets the Employer-specific eligibility requirements for coverage established by your Employer.

Important information on the rules governing the eligibility of employees and their Dependents is found in the Summary Plan Description for the Reta Plan. You should make sure you have a copy of the Summary Plan Description. Contact your Employer for information as to how to obtain a copy of the Summary Plan Description. Additional specific information can be obtained from your Employer.

Service Area Eligibility Requirement

The Participant must live or work in a Kaiser Service Area at the time of enrollment. The Service Area geographic areas are listed at the back of this Benefit Booklet. You cannot enroll or continue enrollment as a Participant or Dependent in a coverage option of the Plan administered by KPIC if you cease to live or work within the geographic areas listed.

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

Persons Barred from Enrolling

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

When You Can Enroll and When Coverage Begins

Your Employer will inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Plan Eligibility Requirements" section in this Benefit Booklet, enrollment is permitted as described below and coverage begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Employer may have additional

requirements, which allows enrollment in other situations.

Open Enrollment Period

The open enrollment period is the time when most people apply for coverage or change coverage. You will have an annual open enrollment period set by your Employer. Your Employer will notify its Employees of the open enrollment period each year.

Special Late Enrollment Periods

A special enrollment period is a time outside open enrollment when you can apply for coverage or change coverage. A special enrollment period begins with a Qualifying Event.

Important information on the rules governing the entitlement of employees and their Dependents to enroll in the Reta Plan outside of the open enrollment period is found in the Summary Plan Description for the Reta Plan. You should make sure you have a copy of the Summary Plan Description. Contact your Employer for information as to how to obtain a copy of the Summary Plan Description.

How to Obtain Health Care Services

As a Participant or Dependent enrolled in the Plan and the coverage option described in this Benefit Booklet, you must receive all Covered Services from Network Providers inside the Service Area, except where specifically noted to the contrary in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section.

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

Services During a State of Emergency

During a national or regional state of emergency, patient care may be handled in a variety of new and unusual locations (e.g., 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.

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 kind of care you need, so Kaiser Permanente has licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

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

• They can tell you what to do if you need care and a Network Facility is closed or you are outside the Service Area

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

Your Personal Network Physician

Personal Network Physicians provide Primary Care and play an important role in coordinating care, including hospital stays and referrals to specialists. For the current list of physicians who are available as Personal Network Physicians, and to find out how to select a Personal Network Physician, please call Customer Service at the number listed in the "Customer Service Phone Numbers" section. You can change your Personal Network Physician for any reason.

Kaiser Permanente generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Kaiser Permanente network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente 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 Kaiser Permanente 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 the Kaiser Permanente 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, the deductible may apply. For more information about Telemedicine Services, you can visit the following webpage: https://about.kaiserpermanente.org/our-story/our-care/is-telehealth-right-for-you

Referrals

You are required to obtain a referral from your personal physician prior to receiving specialty care Services under the Plan. If you receive specialty care Services for which

you did not obtain a referral, you will be responsible for all the charges associated with those Services.

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

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

Self-Referrals Permitted for Some Specialty Care Services

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

- Your personal Network Physician
- Network Generalists in internal medicine, pediatrics, and family practice
- Network chiropractic (if Chiropractic is shown as a self-referred Covered Service in the "Schedule of Benefits" section)

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 Network Specialist:

California Regions

- Mental Health Services,
- Obstetrics/Gynecology
- Optometry
- Services related to sexual or reproductive health
- Substance Use Disorder Treatment Services (not including group visits)

Colorado Region

- Mental Health Services
- Obstetrics and Gynecology
- Substance Use Disorder Treatment Services (not including group visits)

Northwest Region

- Cancer Counseling
- Mental Health Services
- Obstetrics and Gynecology
- Occupational Health
- Ophthalmology
- Social Services
- Substance Use Disorder Services

Prior Authorizations

Certain Services may require Prior Authorization for the Plan to cover them. Your

Network Physician will request Prior Authorization when it is required, except that you must request Prior Authorization in order to receive covered Post-Stabilization Services from Non-Network Providers, as described in the "Emergency, Post-Stabilization, and Out-of- Area Urgent Care You Receive from Non–Network Providers" section.

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

Prior Authorization List

The following Services require Prior Authorization:

- All inpatient and outpatient facility Services (excluding emergencies)
- Office-based habilitative or rehabilitative care:
    - Occupational Therapy
    - Speech Therapy
    - Physical Therapies.
- All Services provided outside a Kaiser Permanente facility
- All Services provided by Non-Network Providers
- Durable Medical Equipment (DME) not listed not listed on the Kaiser Permanente written list of clinical criteria for DME.
- Non-preferred brand and non-preferred generic prescription drugs, called "Tier 3" drugs (none of which are listed on the Kaiser Permanente formulary)

- Specialty drugs, called "Tier 4" drugs, that are not listed on the Kaiser Permanente formulary

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

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

California (Northen):

https://healthy.kaiserpermanente.org/northern-california/pages/utilization-management.

California (Southern):

https://healthy.kaiserpermanente.org/southern-california/pages/utilization-management.

Colorado:

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

Northwest: https://healthy.kaiserpermanente.org/oregon-washington/pages/utilization-management

Step Therapy

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

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

Second Opinions

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

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

Your Identification Card

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

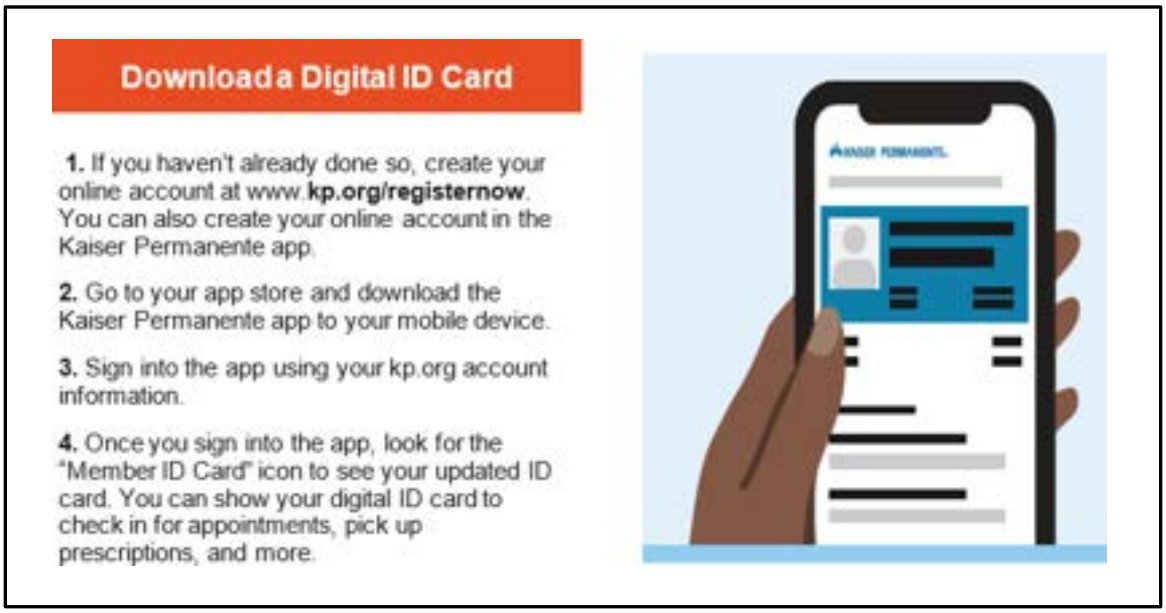
Your ID card is for identification only. For the Plan to cover Services, you must be a current Participant or Dependent on the date you receive the Services. Anyone who is not a Participant or Dependent will be billed for any Services they receive, and the amount billed may be different from the Eligible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

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





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



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 at the number listed in the "Customer Service Phone Numbers" section.

For 24/7 travel support anytime, anywhere, call the Away from Home Travel Line at **1-951-268-3900** or visit www.**kp.org/travel**.

Moving Outside of the Service Area

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

Getting Assistance

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

Interpreter Services

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

Network Facilities

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

- All Network Hospitals provide inpatient Services and are open 24 hours a day, seven days a week.
- Emergency Services are available from Network Hospital Emergency Departments (please refer to www.kp.org for Emergency Department locations in Your area).
- Same-day appointments are available at many locations (please refer to www.kp.org for Urgent Care locations in your area).
- Many Network Facilities have evening and weekend appointments.
- Many Network Facilities have a Customer Service department (refer to www.kp.org for locations in your area).
- Additionally, Kaiser Permanente care is available at certain Target Clinics in Southern California https://kptargetclinic.org

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

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

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

This section explains how to obtain covered Emergency Services (including Post-stabilization Services), and out of area Urgent Care from Non–Network Providers. The care by a Non–Network Provider described in this section is not covered unless it meets both of the following requirements:

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

Emergency Services

If you have an Emergency Medical Condition (see definition in the "Definitions" section), call 911 (where available) or go to the nearest hospital emergency department, , independent freestanding emergency department or Urgent Care clinic licensed to provide Emergency Services. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, the Plan covers Emergency Services you receive from Network Providers or Non-Network Providers anywhere in the world, (subject to the other limitations in this Benefit Booklet).

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "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 are admitted to a non- Network hospital as part of the same visit for your Emergency Medical Condition, your stay will be covered only if Kaiser Permanente is notified within 24 hours or as soon as reasonably possible after stabilization of your Emergency Medical Condition.

Post-Stabilization Services

Post-Stabilization Services including outpatient observation care) that are Medically Necessary and related to your Emergency Medical Condition are covered when they are part of the same visit for screening and stabilization of your Emergency Medical Condition. Post-Stabilization Services also includes Medically Necessary Covered

Durable Medical Equipment after discharged from a hospital and related to the same Emergency Medical Condition. For information on covered Durable Medical Equipment see the "Durable Medical Equipment (DME), External Prosthetics and Orthotics" section. Post-Stabilization Services received from a Non–Network Provider, including inpatient care at a non–Network Hospital, is covered until:

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

Note: You will be responsible for any Services you consent to pay once your attending physician determines you are in a condition to provide voluntary consent; and

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

To request Prior Authorization to receive additional Services from a Non–Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll free at the telephone number on your Kaiser Permanente ID card before you receive the care. A Kaiser Permanente representative will then discuss your condition with the Non–Network Provider. If Kaiser Permanente decides that you require additional Services and that these Services would be covered if you received it from a Network Provider, the Kaiser Permanente representative 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, the Kaiser Permanente representative 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 Services (including any transportation) Kaiser Permanente has authorized, because once your attending emergency physician determines you are able to travel using non-medical/non-emergency medical transportation and there is a Network facility within a reasonable distance considering your medical condition, then any additional Services and/or related transportation provided by Non–Network Providers is not covered unless authorized by Kaiser Permanente.

Urgent Care

Within the Service Area

You may need urgent care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you are in the Service Area and

think you may need urgent care, call the urgent care or advice nurse telephone number (see the "Customer Service Phone Numbers" section or sign on to the **www.members.kp.org** website).

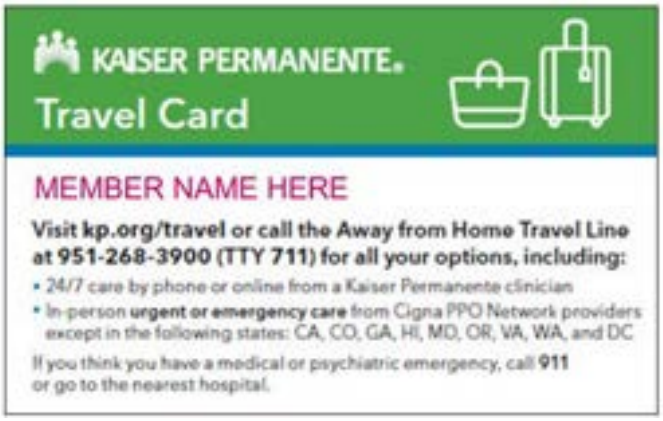
The following Services are not covered under this section:

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

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

Out-of-Area Urgent Care

Use Your Digital ID Card at http://kp.org/travel





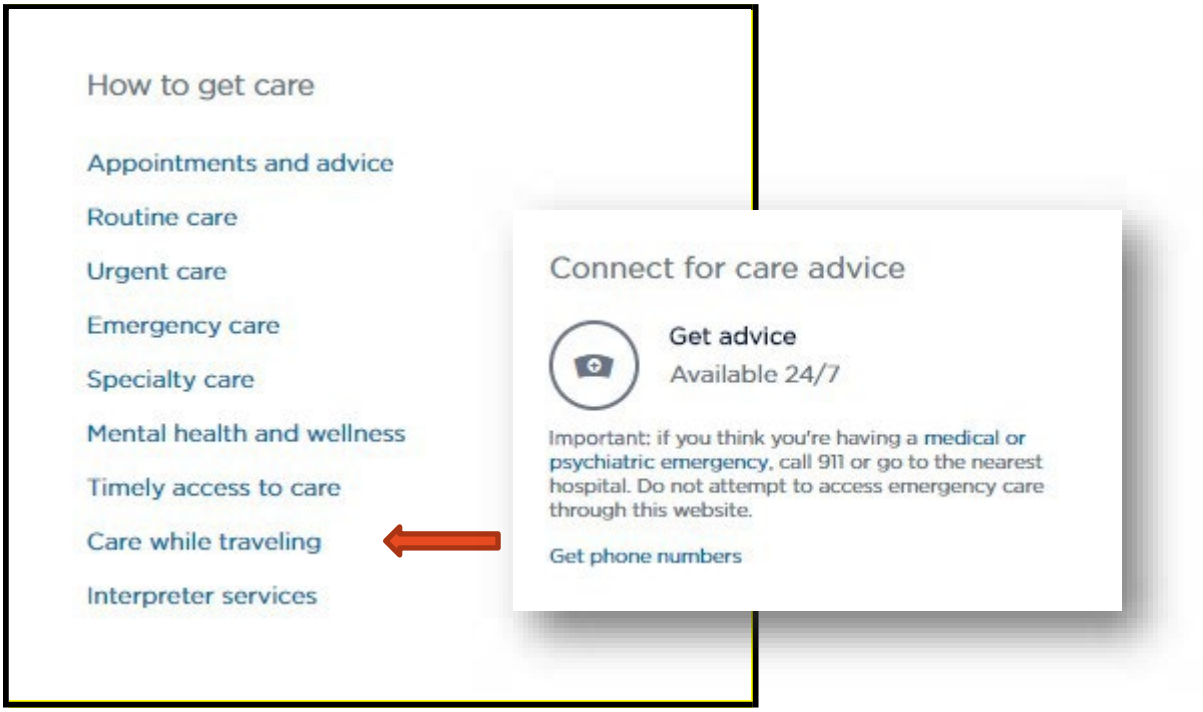
- For **Nonurgent** care you can always schedule in-person visits in states with Kaiser Permanente facilities or use kp.org or the Kaiser Permanente app across the U.S. to get 24/7 care and advice from Kaiser Permanente clinicians by phone or online.
- You may also seek **Urgent** care at The Little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

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

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

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

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



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

The following Services are not covered under this section (instead, refer to the "Benefits and Cost Sharing" section):

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

You May Have to Pay the Bill and Then Make a Claim for Reimbursement

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

Cost Sharing

The Cost Sharing for Emergency Services, and Urgent Care outside the Service Area that you receive from a Non–Network Provider is the Cost Sharing required for the same Services provided by a Network Provider as described in the "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 Sharing for an Emergency Department visit.
- If you received inpatient or outpatient Post-Stabilization Services in a Non-Network Hospital, you pay the Cost Sharing 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 Sharing for Durable Medical Equipment.

Your Rights and Protections Against Certain Surprise Medical Bills

When you get Emergency Services or are treated by a Non-Network Provider at an in-Network hospital or ambulatory surgical center, you are protected from balance billing if it is "Surprise Billing," as defined below. In the case of Surprise Billing, you should not be charged more than your copayments, coinsurance, and/or Deductible amounts.

What is "Balance 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 amounts. 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 the Kaiser Permanente network. Providers and facilities are not engaging in "balance billing" when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under the Plan for the Services provided.

"Out-of-Network" or "Non-Network" refers to providers that haven't signed a contract with KPIC to provide Services at negotiated rates. Non-Network Providers may bill you for the difference between what the Plan pays and what may be the higher amount that the Non-Network Provider charged for the Service. This is called "**balance billing**." The excess amount might not count toward your Deductible or annual Out-of-Pocket Maximum. Also, the Plan may not cover Services when you agree (consent) to receive those Services from the Non-Network Providers.

What is "Surprise Billing"?
"Surprise Billing" is unexpected balance billing by a Non-Network Provider (except when you have consented) that is in excess of the cost-sharing amount for Services provided by a Network Provider in one or more of the following circumstances: (1) Emergency Services, (2) certain other Services performed by a Non-Network Provider at a Network facility, and (3) air ambulance Services from a Non-Network Provider.

Surprise Billing may 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 a Non- Network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or Service.

You're protected from Surprise Billing in these circumstances:

Emergency Services
If you have an Emergency Medical Condition and receive Emergency Services from a Non-Network Provider, the most the Non-Network Provider can bill you is the cost-sharing amount for Services provided by a Network Provider (such as copayments, coinsurance, and deductibles). You **are not responsible for** balance billing for such Emergency Services. This includes Services you may get after have been Stabilized, unless you give written consent and thereby give up your protections not to be balanced billed for these post-stabilization Services.

"Ancillary" Services at an in-network hospital or in-Network ambulatory surgical center

When you get Services from an in-network hospital or in network ambulatory surgical center, certain providers there may be Non-Network Providers. In these cases, the most those Non-Network Providers can bill you is your coverage option's in-Network cost-sharing amounts. 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. You are not responsible for the balance billing of these Non-Network Providers **and they are prohibited from asking you to give up your protections** not to be balance billed. If you get other types of Services at these in-Network facilities, Non-Network Providers **can** balance bill you, but only if you give written consent and give up your protections.

Note: Ancillary providers at Kaiser-owned facilities are always in-Network providers.

You're never required to give up your protections from Surprise Billing. You also aren't required to get care from Non-Network Providers. You can choose a provider or facility in the Network.

Air Ambulance Services

Special rules apply to Surprise Billing by Out-of-Network air ambulance Services. In many cases, an air ambulance Non-Network Provider may not bill you more than the cost of an in-Network air ambulance Service. If you receive air ambulance Services and you have questions about a bill the air ambulance Service wants you to pay, call Customer Service at the number listed in the Customer Service Phone Numbers section at the front of this Benefit Booklet to see if KPIC can help answer your questions.

When Surprise Billing occurs, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and Deductible amounts that you would pay if the Non-Network Provider was in-Network). The Plan may pay any approved additional costs either to you or to out-of-network providers and facilities directly.

- Generally, the 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 Non-Network Provider (your cost-sharing amount) on what the Plan would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you do pay for Emergency Services or non-emergency Services provided by certain Non-Network Providers at an in-network facility toward your in-network Deductible and Out-of-Pocket Maximum

If you think you've been wrongly billed by a provider or facility, you can contact the federal government's No Surprises Help Desk at: **1-800-985-3059.**

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

Benefits and Cost Sharing

The only Services covered under this Plan are those listed as covered in this "Benefits and Cost Sharing" section, subject to the exclusions and other limitations in this Benefit Booklet.

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "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 not listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section;
- The Services are provided, prescribed, authorized, or directed by a Network Physician. The exception to this condition is 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 Health Care Services" section; and
- You receive the Services from Network Providers inside the Service Area. The exceptions to this condition are for the following Services as stated in the referenced sections of this Booklet:
    - Authorized referrals (and associated Ancillary Services) as described under "Referrals" and "Self-Referrals" in the "How to Obtain Health Care Services" section;
    - Emergency Services, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section;
    - Care received outside the Service Area as described in the "Receiving Care in Other Kaiser Permanente Regions" section;
    - Emergency ambulance Service as described under "Ambulance Services" in this "Benefits and Cost Sharing" section.

Note: Non-Network Providers may provide a notice and consent form seeking your (or your authorized representative's) agreement that you will owe the full costs of the items and Services that the Non-Network Provider furnishes. If you (or your Authorized Representative) consent, then you will be financially responsible for payment for those items and Services and you will not be reimbursed for those costs.

Medical Necessity

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

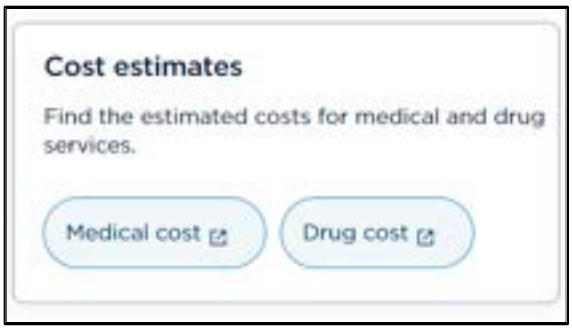
Cost Sharing (Copayments and Coinsurance)

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. 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 Sharing is applied. If the same Service is performed in an office setting by a specialist, the specialty care office visit Cost Sharing is applied. If Services are provided in a hospital clinic setting, separate Cost Sharing 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 Sharing.

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





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

Benefit Maximums and Benefit limits

The "Schedule of Benefits" section describes dollar limits, benefit amounts, and maximum benefit amounts and any day, visit or quantity limits applicable to certain

Covered Services. If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.

Calendar Year Deductible

Generally, you must pay all the costs from providers up to the Deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual Deductible until the total amount of deductible expenses paid by all family members meets the overall family Deductible. The annual Deductible amounts and the Services subject to the Deductible are listed in the "Schedule of Benefits" section.

Annual Out-Of-Pocket Maximums

There are limits to the total amount of Cost Sharing you must pay annually 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 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**.**

After you reach the annual Out-of-Pocket Maximum, you do not have to pay any more Cost Sharing for Service subject to the calendar year Out-of-Pocket Maximum through the end of the calendar year. You will continue to pay Cost Sharing for Covered Services that do not apply to the calendar year Out-of-Pocket Maximum.

The Services included in Out-of-Pocket Maximum are identified in the "Schedule of Benefits" section of this booklet.

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

Outpatient Services

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

- Primary Care office visits including nutrition visits with Registered Dieticians (R.D.), State licensed nutritionists, and Certified Diabetic Educators (ss)
- Specialty Care office visits, including consultation and second opinions
- Acupuncture (if listed as a Covered Service in the "Schedule of Benefits" section)
- Allergy Services
- Ambulance
- Bariatric surgery when you meet certain medical criteria
- Biofeedback
- Blood and blood products and their administration
- Chemotherapy
- Chiropractic care (if listed as a Covered Service in the "Schedule of Benefits" section)

- Dental Services for Dental Anesthesia
- 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
- House calls by a Network Physician when care can best be provided in your home
- Infusion Services provided in an outpatient setting
- Injections (except preventive immunizations)
- Medical supplies used during an outpatient visit
- Medically Necessary surgical or non-surgical treatment of temporomandibular joint (TMJ) dysfunction - Dental treatment of TMJ dysfunction is not covered
- Maternity - prenatal and postnatal visits
- Organ Transplantation
- 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 the "Preventive Services" section for more details)
- Prosthetics and Orthotics
- Radiation therapy
- Respiratory therapy
- Surgical procedures performed in the office
- Ultraviolet light treatments
- Vision Services (if noted as a Covered Service in the "Schedule of Benefits")

Note: See the "Preventive Services" section for information on covered preventive Services.

Hospital Inpatient Services

The following inpatient Services are covered:

- Acute inpatient rehabilitation including physical, occupational, and speech therapy
- Anesthesia
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs and endoscopic procedures
- Dialysis
- Dressings and medical supplies used or applied during an inpatient hospital admission
- Drugs that require administration or observation by medical personnel
- Network Physician Services, including consultation and treatment by specialists
- General nursing care

- Medical social Services
- Medically Necessary surgical or non-surgical treatment of TMJ. Dental treatment of TMJ dysfunction is not covered
- Maternity care and delivery (including cesarean section and newborn care)
- Operating and recovery room including FDA approved internally implanted Prosthetic devices such as pacemakers or artificial hips
- Respiratory therapy
- Room and board, including a private room, if Medically Necessary
- Specialized care and critical care units

Acupuncture Services

With a referral from a Network Provider, 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.

Allergy Services

The Cost Sharing for Specialty Care Services or Primary Care Services is based on the rendering provider. Services include allergy testing, serum and injections.

Ambulance Services

Emergency Ambulance

Emergency Ambulance 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 Ambulance

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

When noted as a Covered Service in the "Schedule of Benefits" section, chiropractic Services for the treatment of neuro musculoskeletal disorders are covered. Services include plain x-rays and adjunctive therapy associated with spinal, muscle or joint manipulation.

To Locate a Network Provider Contact:

California Regions	American Specialty Health Plans of California http://www.ashlink.com/ash/kp or call 1-800-678-9133.
Northwest Region	Heraya Health www.herayahealth.com or 1-800-449-9479

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
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Clinical Trials

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

"Qualified Individual" means an enrollee who is eligible to participate in an Approved Clinical Trial per the trial protocol with respect to treatment of cancer or other life-

threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:

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

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

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by at least one of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the HHS Secretary determines meets all the following requirements:
        i. It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
        ii. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application

Exclusions:

- Non-Approved Clinical Trials
- Investigational items or Services
- Items and Services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient
- Services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

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 anesthesia

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

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

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

Exclusions:

- 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.
- Coverage will not be provided for accidental injury to teeth. That is, Services to repair sound natural teeth if related to an accidental injury are not covered.
- Coverage will not be provided for dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders). This exclusion does not apply to medical Services to correct TMJ disorders.
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Dialysis Care

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

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

After the referral to a dialysis facility, the Plan covers equipment, training and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Durable Medical Equipment (DME), External Prosthetics, and Orthotics

DME, external prosthetics, and orthotics must meet Kaiser Permanente's clinical criteria for DME to be covered. Kaiser Permanente's clinical criteria are set forth in a written list of DME, external prosthetics, and orthotics that are covered. 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" section and not the DME 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 equipment item that adequately meets your medical needs. Kaiser Permanente will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. Coverage includes fitting and adjustment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of 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 clinical criteria guidelines allow you to obtain non-listed DME if they would otherwise be covered if KPIC criteria are met. To request an exception, contact Customer Service.

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

External Prosthetics
External Prosthetics satisfy Kaiser Permanente's clinical criteria for DME, External Prosthetic and Orthotic to be covered. Examples of external Prosthetic covered items include:

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

Orthotics
Orthotics must satisfy Kaiser Permanente's clinical criteria for DME, External Prosthetic and Orthotic to be covered.

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

Exclusions:

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

- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Education and Training for Self-Management

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

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

Emergency Services

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

Fertility Treatment Services

Many fertility Services are excluded from coverage as set forth in the section of this Benefit Booklet titled "Exclusions: Services and Treatments That Are Not Covered by the Plan."

Services to diagnose underlying medical conditions causing infertility are covered. Covered Services include any necessary diagnostic procedures, laboratory and radiology Services, and drugs administered by medical personnel. See also the "Natural Family Planning" section for more information on covered fertility Services.

Exclusions:

- Donor semen or eggs and Services related to their procurement and storage
- Cryopreservation and Storage greater than 6 months
- Advanced reproductive technologies such as in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT) and variations of these procedures
- Any experimental, investigational or unproven procedures or therapies
- Artificial Insemination
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Home Health Services

Skilled, part-time or intermittent home health Services are covered when you are confined to your home. Skilled home health Services are those Services provided by nurses, medical social workers, and physical, occupational and speech therapists. Medical supplies used during a covered home health visit are also covered. The Services are

covered only if a Network Physician determines that you require skilled care, and it is feasible to maintain effective supervision and control of your care in your home. Home health aide Services are covered only when you are also getting covered home health care from one of the licensed providers mentioned previously.

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

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

The following types of Services and supplies are covered only as described under these headings in this "Benefits and Cost Sharing" section:

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

Exclusions:

- Custodial Care - (For example: care an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training) This care is excluded even if the care would be covered if it were provided by a qualified medical professional in a hospital or a skilled nursing facility.
- Full time nursing care in the home
- Homemaker services and supplies, including meals delivered to your home
- Home health care a Network Physician determines may be more appropriately provided for you in a Network Facility, Network Hospital or a Network Skilled Nursing Facility
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Home Infusion Services

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

- Administration
- Professional pharmacy Services
- Care coordination
- All necessary supplies and equipment, including delivery and removal of supplies and equipment

- Drugs and Biologicals
- Nursing visits related to infusion Hospice

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

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

- Network Physician and nursing care
- Counseling and bereavement Services
- Physical, occupational, speech or respiratory therapy for purposes of symptom control or to enable you to maintain activities of daily living.
- Medical social Services
- Home health aide and homemaker Services
- Covered Durable Medical Equipment and Medical supplies
- Palliative care prescription drugs that are covered or approved in advance when prior authorization is required.
- 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 Sharing.
The Plan covers physician charges for maternity care, delivery and postnatal care. Also covered are hospital Services (including network birthing centers) and newborn care.

Notes:

1) If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.

2) Circumcision is covered for eligible newborns during the first 31 days of life regardless of Medical Necessity and thereafter only when Medically Necessary.

3) Newborn child. A Participant or Participant Spouse's newborn child is automatically covered under the Participant's group health plan coverage for the first 31 days after birth. Charges for well newborn care (as defined by hospital billing) billed as part of the mother's bill will be attributed to the mother's Cost Sharing requirements. Separately billed well newborns may be subject to his/her own Cost Sharing and Deductible, check the "Schedule of Benefits" section.
Eligible sick newborns are subject to all Plan provisions including his/her own Cost Sharing requirements. If the parent of the newborn child is a Dependent child of the Participant, the newborn is provided benefits.

4) During the first 31–day period after birth, benefits for an eligible newborn child shall consist of Medically Necessary care for injury and sickness, including well child care and treatment of medically diagnosed congenital defects and birth abnormalities. Services provided during the first 31 days of coverage may be subject to the Cost Sharing requirements and any benefit maximums applicable to other sicknesses, diseases and conditions otherwise covered. **Note**: If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days.

5) To continue the newborn's participation in the Plan beyond the 31-day period after the newborn child's birth, contact your Employer. Your Employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15, you have 31 days from the birth to notify the employer of the newborn's birth.

* Charges for well newborns (as defined by the hospital), billed as part of the mother's bill will be attributed to the mother's Cost Sharing 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 Sharing 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" section of this Benefit Booklet.

Mental Health Services

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

Inpatient Mental Health Services

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

Outpatient Mental Health Services

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

Natural Family Planning Services

Natural family planning Services, including fertility awareness education, fertility diagnostic Services, and restorative reproductive medicine, are covered by Network Providers and by providers affiliated with MyCatholicDoctor. For more information, access the information at https://mycatholicdoctor.com/reta-kp/ .

Outpatient Lab, 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 Sharing.

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

Note: See the "Preventive Services" section for information on covered preventive laboratory, x-ray, imaging and diagnostic procedures.

Outpatient Prescription Drugs

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

1. The item is prescribed by a Network Provider authorized to prescribe drugs or by one of the following Non-Network Providers:
   - A dentist;
   - A Non-Network Provider to whom you have been referred by a Network Physician;
   - A Non-Network Provider if you got the prescription in conjunction with covered Out-of-Area Urgent Care or Emergency Services;
   - A Community Pharmacy in a Service Area outside of California; or
   - The first refill of a prescription originally filled prior to enrollment in the Plan.
2. Prior authorization of Medical Necessity must be granted if prior authorization is required as set forth in the section entitled "Required Prior Authorization List."
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:
    - Drugs for the treatment of sexual dysfunction;
    - Smoking Cessation products; or
- Drugs that don't require a prescription but are listed on Kaiser Permanente's drug formulary;
- Diabetic supplies such as insulin, syringes, pen delivery devices, blood glucose monitors, test strips and tablets. Other diabetic supplies may be covered under Durable Medical Equipment; or
- Specialty drugs – high-cost drugs contained on the Kaiser Permanente specialty drug list. To obtain a list of specialty drugs on the Kaiser Permanente 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 under the Plan by the Kaiser Permanente Pharmacy and Therapeutics Committee. Generally, if your prescription medications are not listed on the Kaiser formulary, you will have to pay for them out of pocket.

Kaiser's formulary guidelines, however, allow in certain circumstances for exceptions in order for you to obtain non-formulary prescription drugs (that is, drugs not listed on the drug formulary for your condition). If an exception is requested and the criteria for an exception under the guidelines are met, the drug will be covered by the Plan. To request a formulary exception, contact Customer Service. Prescriptions written by dentists are not eligible for non-formulary exceptions.

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

If applicable, Step Therapy will be required before approval of certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

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

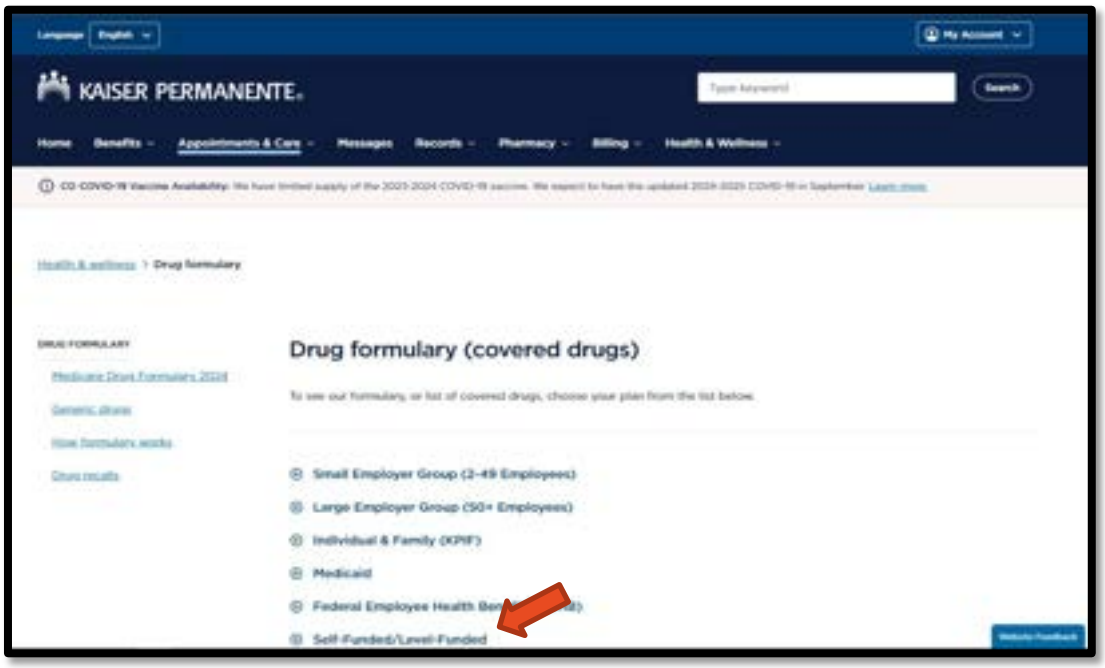
- Controlled substances as determined by state and/or federal regulations;
- Medications that require special handling; and
- Medications affected by temperature.

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, learn more about mail order, or print a claim form, sign on to the www.kp.org website and click on "Pharmacy." You may also call OptumRx at 1-866-427-7701.



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



For outpatient prescription drugs and/or items covered under this Outpatient-Prescription Drug section and obtained at a pharmacy owned and operated by Kaiser Permanente, you may use certain manufacturer coupons you have procured, when and approved by Kaiser Permanente and as allowed by law (i.e., for high deductible health plans that are used with a health savings account, your use of a coupon does not count toward your Deductible), as payment of your Cost Sharing. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Sharing for your prescription. If the coupon is for an amount greater than the Cost Sharing amount you owe for your prescription, no credit, cash or other refund will be given for the excess amount. When a coupon is accepted toward satisfaction of your Cost Sharing, an amount equal to the coupon value and, if applicable, any additional amount that you pay, will accumulate to Out-of-Pocket Maximum. Kaiser Permanente reserves the right to change the terms and conditions of its coupon program, including but not limited to the types and amounts of coupons that will be accepted at any time without prior notice. You may obtain information regarding the Kaiser Permanente coupon program at www.kp.org and search on the term "coupons". Acceptance of Your coupon does not relieve you of your responsibility regarding Cost

Sharing if the drug manufacturer does not honor the coupon in whole or in part or if Kaiser Permanente later determines that the coupon was not allowed. www.kp.org/rxcoupons.

Exclusions:

- If a Service is not covered under this Plan, any drugs or supplies needed relating to that Service are not covered
- Compounded products unless the drug is listed on the drug formulary or one of the ingredients requires a prescription by law
- Contraceptive drugs including the emergency contraceptive pill and devices, such as diaphragms and cervical caps (See also the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section for details)
- Drugs used to enhance athletic performance
- Drugs used in the treatment of weight control
- Experimental or Investigational Drugs
- Drugs prescribed for cosmetic purposes
- Replacement of lost, damaged or stolen drugs
- Drugs that shorten the duration of the common cold
- Special packaging - Packaging of prescription medications is limited to Kaiser Permanente standard packaging
- Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product.
- Drugs or devices for which there is an over-the-counter equivalent
- Drugs used in fertility treatment
- See also the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Preventive Services

Preventive Services are measures taken to prevent or detect diseases rather than curing them or treating their symptoms. Preventive Services are those which:

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

The Preventive Services that are required by the Patient Protection and Affordable Care Act (PPACA) are covered in most cases. Preventive Services that are covered are not subject to Deductibles, Copayments, or Coinsurance. Consult with your physician to determine what Services are appropriate for you. Preventive Services will be covered based on the member's medical status.

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 list of the current preventive Services recommended by the United States Preventive Services Task Force (USPSTF) that are required under the Patient Protection and Affordable Care Act to be provided without application of any Cost Sharing, please call the

Customer Service number on the back of your ID card or visit the following webpage: www.healthcare.gov/center/regulations/prevention.html .

Exclusions:

- Contraceptive services are not covered even if classified as Preventive Services. See the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section for details.
- State-specific preventive mandates and recommendations in effect for less than one year are not covered.
- Personal and convenience supplies associated with lactation equipment such as pads, bottles, and carrier cases
- Upgrades of lactation equipment, unless determined to be Medically Necessary and prescribed by your physician

Note: The following Services are not covered as Preventive Services, but may nevertheless be Covered Services elsewhere in this Benefits Booklet:

- Lab, imaging, and other ancillary Services associated with prenatal care not included as a part of routine prenatal care.
- Non-routine prenatal care visits.
- Post-partum visits. (In the case of high deductible health plan coverage that is compatible with eligibility for a health savings account, a Deductible, copayment or coinsurance may apply.)

Reconstructive Surgery Services

Coverage is provided for inpatient and outpatient Services for Reconstructive Surgery that

- Will result in a significant improvement in physical function for conditions arising from or directly related to any of the following: a physical congenital defect or physical developmental abnormality; a personal injury resulting from accident or physical trauma; or an infection, tumor, or disease; or
- Will correct a significant disfigurement arising from or directly related to any of the following: a physical congenital defect or physical developmental abnormality; a personal injury resulting from accident or physical trauma; or an infection, tumor, or disease.

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 and other cosmetic Services and supplies intended primarily to change your appearance, including cosmetic surgery related to bariatric surgery;
- Sterilization;
- Gender reassignment surgery.
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section.

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

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

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

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

Exclusions:

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

The Following Additional Habilitative Services are Covered:

Treatment for Pervasive Developmental Disorders

Covered Services for pervasive developmental disorder or autism include:

- Medically Necessary Inpatient, Skilled Nursing Home and Outpatient care;
- Behavioral health treatment;
- Applied behavior analysis and evidence-based behavior intervention programs that

develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism.

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

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

Note that certain Services require Prior Authorization:

- All inpatient and outpatient facility Services (excluding emergencies)
- Office-based habilitative or rehabilitative care:
    - Occupational Therapy
    - Speech Therapy
    - Physical Therapies.
- All Services provided outside a Kaiser Permanente facility
- All Services provided by Non-Network Providers
- Durable Medical Equipment (DME) not listed on the Kaiser Permanente written list of clinical criteria for DME.
- Non-preferred brand and non-preferred generic prescription drugs, called “Tier 3” drugs (which are categorized as “not listed” on the Kaiser Permanente formulary)
- Specialty drugs, called “Tier 4” drugs (which are not listed on the Kaiser Permanente formulary)

Exclusions:

- Services not identified in an approved treatment plan;
- Teaching manners and etiquette;
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning;
- Items and services for the purpose of increasing academic knowledge or skills;
- Teaching and support services to increase intelligence;

- Academic coaching or tutoring for skills such as grammar, math, and time management;
- Teaching you how to read, 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.
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Skilled Nursing Facility Services

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

- Network Physician and nursing Services;
- Room and board;
- Medical social Services;
- Prescribed drugs;
- Respiratory therapy;
- Physical, occupational, and speech therapy;
- Medical equipment ordinarily furnished by the Skilled Nursing Facility;
- Medical supplies;
- Imaging and laboratory Services ordinarily provided by Skilled Nursing Facilities; 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. Rehabilitation Services needed due to a substance use disorder in a licensed residential treatment Network Facility are also covered.

Outpatient

The following Services for treatment of substance use disorders are covered:

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

Transplant Services

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

- Bone marrow transplant and stem cell rescue
- Cornea

- Heart
- Heart & lung
- Liver
- Lung
- Kidney
- Simultaneous kidney & pancreas
- Pancreas
- Pancreas after kidney alone
- Small bowel
- Small bowel & liver

Transplant 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 KPIC. 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 or 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:

- KPIC does not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Organ or tissue transplants which are experimental or investigational are not covered.
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

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.

Vision Exams (routine)

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

Corrective lenses, eyeglasses, frames, and contact lenses (including the fitting of contact lenses) may be covered in your benefit plan. Please see the "Schedule of Benefits" section.

Exclusions:

- If vision hardware is not covered, this exclusion does not apply to Services covered under "Durable Medical Equipment (DME), External Prosthetics, and Orthotics" in the "Benefits and Cost Sharing" section
- All Services related to eye surgery for correcting refractive defects such as nearsightedness, farsightedness or astigmatism (for example, radial keratotomy and photo-refractive keratectomy)
- Orthoptic therapy, a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision
- Visual training
- Low vision aids and Services
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Vision Hardware

If shown as a Covered Service within the "Schedule of Benefits" section, eyeglass lenses, frames, contacts, and fittings are covered up to the Allowance and frequency specified in the "Schedule of Benefits" section. Any unused portion of the Allowance at the point of sale may not be used later. If you have a change in vision greater than .50 diopter within 12 months of your last eye exam, replacement lenses are covered up to the following Allowance:

- $60 for single vision and cosmetic contact lenses
- $90 for multifocal lenses

The replacement lens must be for the same product type as the original lens.

Exclusions:

- Industrial and athletic safety frames
- Eyeglass lenses, sunglasses and contact lenses with no refractive value
- Tinted lenses
- Replacement of lost, broken, or damaged lenses, frames, and contact lenses
- Lens adornment, such as engraving, faceting, or jewelling

- Low-vision devices
- See also the exclusions listed in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section

Exclusions: Services and Treatments That Are Not Covered by the Plan

The Services and treatments listed in this section are excluded from coverage by the Plan even if they are Medically Necessary. These exclusions apply to all Services that would otherwise be covered. Additional exclusions that apply only to a particular Service are listed in the description of that benefit in the "Benefits and Cost Sharing" section of the Benefit Booklet.

Abortion Procedures – No coverage is provided for abortion procedures.

This exclusion applies to, but is not limited to, Procured Elective Abortions. For the purposes of this exclusion, a “Procured Elective Abortion” means the deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth, whether chosen for its own sake or for a further end.

This exclusion applies to any intervention, whether surgical or chemical, whose sole immediate effect is the destruction of a living human embryo or fetus or the removal of a living embryo or fetus from the uterus before viability, which includes the interval between conception and implantation of the embryo.

This exclusion applies to removal of a living human fetus after viability with the sole intent for the removal to result in the death of the fetus.

This exclusion applies, in the case of an extrauterine (e.g., ectopic) pregnancy, to any intervention which constitutes a procured elective abortion. For the purposes of this exclusion, the use of surgical and other measures, such as salpingostomy, salpingectomy, or methotrexate, in accord with accepted medical standards to address an extrauterine (e.g., ectopic) pregnancy does not constitute a Procured Elective Abortion.

This exclusion applies to prenatal diagnosis when undertaken with the intention of aborting an unborn child with a serious defect.

This exclusion does not apply to operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious physical pathological condition of a pregnant woman when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

This exclusion does not apply to Medically Necessary treatment for the treatment of the trauma of abortion or complications resulting from an abortion, such as infections or hemorrhages.

Assisted Conception Services and Artificial Insemination – No coverage is provided for any reproductive measure or technique of assisted conception that separates the unitive and procreative ends of the conjugal act or that substitutes for the conjugal act itself. Specific services that are covered by this exclusion include the harvesting or stimulation of the human ovum, in vitro fertilization, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes,

ovarian tissue, or sperm, or services incident to or resulting from procedures for a surrogate mother.

This exclusion applies to, but is not limited to, measures or techniques of assisted conception that involve the cryopreservation or destruction of human embryos (which include zygotes and blastocysts), or that involve the cryopreservation of human gametes, for the purpose of methods of infertility treatment that are excluded from coverage.

This exclusion applies to, but is not limited to, measures or techniques of assisted conception that involve the post-mortem retrieval of human gametes.

This exclusion applies to, but is not limited to, heterologous fertilization, which is any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouse.

This exclusion applies to, but is not limited to, homologous artificial fertilization (i.e., the use of the gametes of the two spouses joined in marriage) when it is used to achieve extracorporeal conception or when it involves the destruction or cryopreservation of human embryos.

This exclusion does not apply to homologous artificial fertilization within marriage in situations in which the technique or measure utilized does not substitute for the conjugal act.

This exclusion does not apply to services that help married couples conceive and do not separate the unitive and procreative ends of the conjugal act and does not substitute for the conjugal act itself.

This exclusion does not apply to restorative reproductive medicine for the treatment of infertility.

This exclusion does not apply to services and procedures to rule out the underlying medical causes of infertility.

Assisted Suicide and Euthanasia – No coverage is provided for euthanasia or assisted suicide procedures.

This exclusion does not apply, in the case of a patient in the terminal phase of an illness, to palliative measures, administered with the proper consent of the patient or surrogate, that induce a temporary or intermittent loss of consciousness and typical pain-management therapies have been ineffective, provided there is a plan of care is in place that addresses the degree and length of sedation.

This exclusion does not apply, in the case of a dying person, to the administration of medicines directed toward alleviating or suppressing pain and other symptoms, even if the therapy may indirectly shorten the person's life so long as the dose is therapeutic and the intent is not to hasten death.

Blood – No coverage is provided for 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. No coverage is provided for the collection, processing, and storage of blood donated by donors whom you designate.

This exclusion does not apply to the procurement and storage of cord blood when Medically Necessary for the imminent use at the time of collection for a designated recipient.

Behavioral or Conduct Problems – No coverage is provided for therapies and Services delivered in a non-clinical setting such as educational therapies and programs for behavioral or conduct problems.

Care in a Halfway House – No coverage is provided for any Services while you are a resident in a halfway house

Certain Exams and Services – No coverage is provided for routine physical examinations, immunizations, and vaccinations (however administered) for licensure, employment, travel, insurance, court order, parole, or probation or while incarcerated.

Contraceptives – No coverage is provided for any contraceptive interventions that have the principal purpose, whether as an end or a means, to render procreation improbable.

This exclusion does not apply, in the case of a sexual assault, to services and medications to prevent ovulation, sperm capacitation, or fertilization if, after appropriate testing, there is no evidence that conception has occurred already.

Cosmetic and Other Services to Alter or Reshape Body– No coverage is provided for interventions, whether surgical, hormonal, or by way of genetic engineering, that aim not to restore, but only to alter or reshape, structures or tissues of the body in form or function.

This exclusion applies to cosmetic surgery. For the purposes of this exclusion, "cosmetic surgery" is any procedure that is directed at improving appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

This exclusion does not apply to Medically Necessary treatment of complications resulting from cosmetic surgery or other excluded treatment, such as infections or hemorrhages.

This exclusion does not apply to Reconstructive Surgery, unless (1) the Reconstructive Surgery is intended to create a normal appearance and the surgery offers only a minimal change to appearance, or (2) there is a more appropriate procedure that is not excluded from coverage. "Reconstructive Surgery" is defined in the Definitions section.

This exclusion does not apply to the removal or suppression of the function of one part of the body for the sake of the body as a whole if the following conditions are satisfied:

(1) there is no other reasonable means of addressing the physical pathological condition, (2) the efficacy of the procedure is reasonably well-assured, and (3) the benefits expected from the procedure are proportionate to the burdens it imposes. These conditions are satisfied when the body part itself is diseased and presents a risk to the life or well-ordered functioning of the body as a whole. These conditions are also satisfied when a healthy body part presents a risk to the life or well-ordered functioning of the body as a whole because its present or its functioning contributes to a serious physical pathology in another part of the body.

Custodial, Rest, and Domiciliary Services – No coverage is provided for home Services, hospitalization, or confinement in a health facility primarily for rest, Custodial Care (as defined in the Definitions section), or domiciliary care. For the purposes of this exclusion, "domiciliary care" means a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities

Dental Services – No coverage is provided for dental care. including dental X-rays, Dental Services following accidental injury to teeth, dental appliances, dental implants, or orthodontia. This exclusion does not apply to Dental Services necessary for or resulting from medical treatment, such as surgery on the jawbone, and radiation treatment is limited to:

(a) emergency Dental Services; or

(b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with Non-Covered Dental Services are excluded, except when Medically Necessary for Participants who have a medical condition that your Network Provider determines would place you at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by your Network Provider.

Designated Blood Donations – No coverage is provided for the collection, processing, and storage of blood donated by donors whom you designate. This exclusion does not apply to the procurement and storage of cord blood when Medically Necessary for the imminent use at the time of collection for a designated recipient.

Detained or Confined Persons – No coverage is provided for Services provided or arranged by criminal justice officials or institutions while you are detained or confined, except for Services which meet the requirements of Emergency Services.

Education – No coverage is provided for Services determined by the Claims Administrator to be primarily educational in nature. This exclusion does not apply to Services described as "Education and Training for Self-Management" in the "Benefits and Cost Sharing" section.

Employer Responsibility – No coverage is provided for any Services that the law requires an employer to provide, such as by way of a workers' compensation or

employer liability law. When the Plan pays for any of these Services, the Plan may recover the charges for the Services from the employer.

Equipment for Comfort or Convenience – No coverage is provided for equipment that serves comfort or convenience functions or is primarily for the convenience of a person caring for the Participant or Dependent. Examples of the types of equipment that are excluded from coverage include exercycles, other physical fitness equipment, elevators, Hoyer lifts, shower or bath benches, air conditioners, air purifiers and filters, batteries and chargers, dehumidifiers, humidifiers, and air cleaners and dust collection devices.

Excluded Providers – No coverage is provide for any Services, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by federal or State regulatory agencies. This exclusion does not apply to Emergency Services.

Experimental or Investigational Services – No coverage is provided for any Services that are determined by the Claims Administrator to be Experimental or Investigational (as defined in the Definitions section).

Eye Surgery – No coverage is provided for radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for any of those procedures.

Family Services – No coverage is provided for Services performed by your spouse, child, brother, sister, parent, or member of your household.

Genetic Testing – No coverage is provided for genetic testing and related Services that are not for the diagnosis of a disease or predisposition to a disease. This exclusion does not apply to genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease or predisposition of disease and to develop treatment plans. This exclusion does not apply to preconception and prenatal testing for detection of congenital and heritable disorders and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary as determined by a Network Provider, in accordance with applicable law. However, testing for family members who are not Participants is always excluded.

Government Agency Responsibility – No coverage is provided for any Services that the law requires be provided only by or received only from a government agency. If the Plan pays for any of these Services, the Plan may recover the charges for the Services from the government agency. This exclusion does not apply to Services provided by Medicaid.

Hearing Aids – No coverage is provided for hearing aids, hearing aid examinations for the appropriate type of hearing aid, hearing aid fitting, or hearing aid recheck appointments.

Hypnotherapy – No coverage is provided for hypnotherapy (hypnosis), or Services related to hypnotherapy.

Intermediate Services – No coverage is provided for Services in an intermediate care facility.

Legal Prohibition – No coverage is provided for Services to the extent the charges for the Services are prohibited by any law of the jurisdiction in which the Participant or Dependent resides at the time the expense is incurred.

Licensed Provider – No coverage is provided for Services of a Provider acting outside the scope of his or her license.

Low-Vision Aids – No coverage is provided for video-assisted visual aids or video magnification equipment for any purpose**.**

Massage Therapy Services – No coverage is provided for massage therapy and related Services, except when a Network Provider makes a referral for Services in accord with the criteria of the referring Medical Group. Such Services are subject to the benefit limitations shown above under "Alternative Care."

Medical Supplies for Home Use – No coverage is provided for disposable supplies for home use, other than urological and ostomy supplies.

Naturopathy Services – No coverage is provided for naturopathy and related Services, except when a Network Provider makes a referral for Services in accord with Medical Group criteria. Such Services are subject to the benefit limitations shown above under "Alternative Care."

Non-Medically Necessary Services – No coverage is provided for Services that are not Medically Necessary.

Non-reusable Medical Supplies – No coverage is provided for non-reusable medical supplies, except for splints, slings, and wound dressings, including bandages and ace wrap bandages, supplied and applied by a licensed health care provider, while providing a covered Service.

Outpatient Prescription Drugs, Supplies, and Supplements Exclusions – No coverage is provided for the following:

• Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.

• Any drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) determined that use of that drug for that indication is contraindicated.

• Any drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the KPIC Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health

and Human Services.

• Any drugs, supplies, and supplements that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to drugs, supplies, or supplements that the Plan's drug formulary lists for your condition.

• Any drugs that the FDA has not approved.

• Any drugs used in weight management.

• Any drugs used to enhance athletic performance.

• Any extemporaneously compounded drugs, unless the formulation is approved by KPIC's Regional Formulary and Therapeutics Committee.

• Any mail-order drugs for anyone who is not a resident of Oregon or Washington.

• Any replacement of drugs, supplies, and supplements due to loss, damage, or carelessness.

• Any contraceptive drugs and devices including injectable contraceptives (except in cases of sexual assault if there is no evidence of conception).

• Any drugs used in the treatment of infertility.

• Any drugs used in the treatment of weight control.

• Any end-of-life drugs.

Personal Comfort Items – No coverage is provided for personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and items not directly related to medical care, such as meals for guests and accommodations, hospital admission kit, barber services, telephone charges, internet service, radio and television rentals, homemaker Services, travel expenses, over the counter convenience items, and take-home supplies.

This exclusion does not apply to items provided at an inpatient mental health facility that are considered to be part of the costs of lodging.

Private Duty Nursing – No coverage is provided for private duty nursing in home or long-term facility or as a registered bed patient.

Professional Contact Lens Services – No coverage is provided for professional Services for fitting contact lenses or follow-up care for contact lenses.

Religious, Personal Growth Counseling or Marriage Counseling – No coverage is provided for Services and treatment related to religious, personal growth, or marriage counseling, unless the primary patient has a diagnosis of a Mental Health Condition.

Services Performed by Unlicensed Persons – No coverage is provided for Services provided by persons who are not required to have licenses or certificates issued by the state to provide their Services and where the Participant's condition does not require that the Services be provided by a licensed health care provider.

Services Provided Outside the United States – No coverage is provided for Services received outside the United States, whether or not the Services are available in the United States, other than Emergency Services.

Services Related to a Non-Covered Services – No coverage is provided for Services related to Services that are not covered. This exclusion does not apply to Services the Plan would otherwise cover if they are to treat complications which arise from the non-covered Service. This exclusion does not apply to Medically Necessary Services for a Participant or Dependent enrolled in and participating in a qualifying clinical trial if the Plan would typically cover those Services absent a clinical trial.

Services That are Not Health Care Services – No coverage is provided services that are not services, supplies, or Items for health care. This exclusion applies, for example, to the following:

- 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 that increase 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 art, dance, horse riding, music, play or swimming.
- Teaching skills for employment or vocational purposes.
- Vocational training or teaching vocational skills.
- Professional growth courses.
- Training for a specific job or employment counseling.
- Aquatic therapy and other water therapy.

Sex or Gender Reassignment Services – No coverage is provided for interventions, whether surgical, hormonal, or by way of genetic engineering, that aim to transform the sexual characteristics of a human body into those of the opposite sex or to nullify the sexual characteristics of the human body.

This exclusion applies to the removal of an organ in order to allow for its replacement with a simulation of the corresponding organ of the opposite sex; the removal of an organ because the absence of the organ is a characteristic of the opposite sex; and the reconfiguring of an organ in order to make the organ resemble as much as possible the corresponding organ of the opposite sex.

This exclusion applies to drug or hormone therapy to induce or suppress changes to align an individual's primary or secondary sex characteristics with a gender identity that does not conform to the individual's biological sex, including the administration of puberty-suppressing hormones or masculinizing or feminizing hormones.

This exclusion does not apply to health care services, such as counseling, intended to mitigate the suffering of those who suffer from gender incongruence or gender dysphoria, while also respecting the fundamental order of the human body.

Sterilization – No coverage is provided for any sterilization procedures (for example, a

vasectomy), regardless of whether the induced sterility is intended to be permanent or temporary.

This exclusion does not apply to procedures that induce sterility when their direct intended effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.

This exclusion does not apply to procedures that induce sterility when their direct intended effect is the alleviation of a specific fatal pathology that is evidenced by a genetic test or family history and a simpler treatment is not available.

This exclusion does not apply to the removal or suppression of the function of one part of the body for the sake of the body as a whole if the following conditions are satisfied: (1) there is no other reasonable means of addressing the physical pathological condition, (2) the efficacy of the procedure is reasonably well-assured, and (3) the benefits expected from the procedure are proportionate to the burdens it imposes. These conditions are satisfied when the body part itself is diseased and presents a risk to the life or well-ordered functioning of the body as a whole. These conditions are also satisfied when a healthy body part presents a risk to the life or well-ordered functioning of the body as a whole because its present or its functioning contributes to a serious physical pathology in another part of the body.

Supportive Care and other Services – No coverage is provided for supportive care primarily to maintain the level of correction already achieved, care primarily for the convenience of the Participant or Dependent, or care on a non-acute, symptomatic basis.

Surrogacy – No coverage is provided for Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Covered Person who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

See "Surrogacy Arrangements" for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse the Plan for any Services that the Plan covers and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Third Generation Dependents – No coverage is provided for Services related to third generation dependents, unless covered as a Dependent.

Travel and lodging – No coverage is provided for transportation or living expenses for any person, including the patient, except for (a) Medically Necessary ambulance Service covered under “Ambulance Services,” and (b) certain expenses that KPIC has Pre-Authorized in accord with the travel and lodging guidelines under “Transplant Services.”

Treatments Using Tissue from Aborted Fetuses or Embryonic Cells – No coverage is provided for procedures or treatments that utilize tissue from an aborted fetus or cells harvested directly or indirectly (by way of a stem cell line) from a human embryo that was created or destroyed for the principal purpose of harvesting its cells.

Vision therapy and Orthoptics or Eye Exercises – No coverage is provided for Services related to vision therapy, orthoptics, and eye exercises.

Wigs and Toupees – No coverage is provided for wigs, toupees, or similar types of cranial protheses, except as may be covered in the "Durable Medical Equipment (DME), External Prosthetics and Orthotics" section.

General Limitations, Coordination of Benefits, and Reductions

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in the "Schedule of Benefits" section found at the end of this Benefit Booklet; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "General Limitations, Coordination of Benefits, and Reductions" section.

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 a 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, nor KPIC, nor Kaiser Permanente, nor any Network Provider, however, 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 insurance contract or 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, capitalized 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 plans or contracts are used to provide coordinated coverage for members of a group, the separate contracts or plans are considered parts of the same Coverage Plan and there is no COB among those separate contracts or plans.

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

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

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

- If a Covered Person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.
- If a person is covered by two or more Coverage Plans that compute their benefit payments based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any

amount more than the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not an Allowable Expense.

- If a person is covered by two or more Coverage Plans that provide benefits or Services based on negotiated fees, an amount more than the highest of the negotiated fees is not an Allowable Expense.
- If a person is covered by one Coverage Plan that calculates its benefits or Services based on usual and customary fees and another Coverage Plan that provides its benefits or Services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans. However, if the provider has contracted with the Secondary Coverage Plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Coverage Plan to determine its benefits.
- The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a calendar year.

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

a. For a dependent child whose parents are married or are living together:

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

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

b. For a dependent child whose parents are divorced or separated or are not living together:

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

(ii) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:

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

The Coverage Plan of the spouse of the non- custodial parent

c. For a dependent child covered under more than one Coverage Plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active or inactive (retired or laid-off) employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The Coverage Plan covering that same person as a retired or laid-off employee is the Secondary Coverage Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a dependent of a retiree or laid-off employee. If the other Coverage Plan does not have this rule, and thus, the Coverage Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in paragraph 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 in paragraph 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.

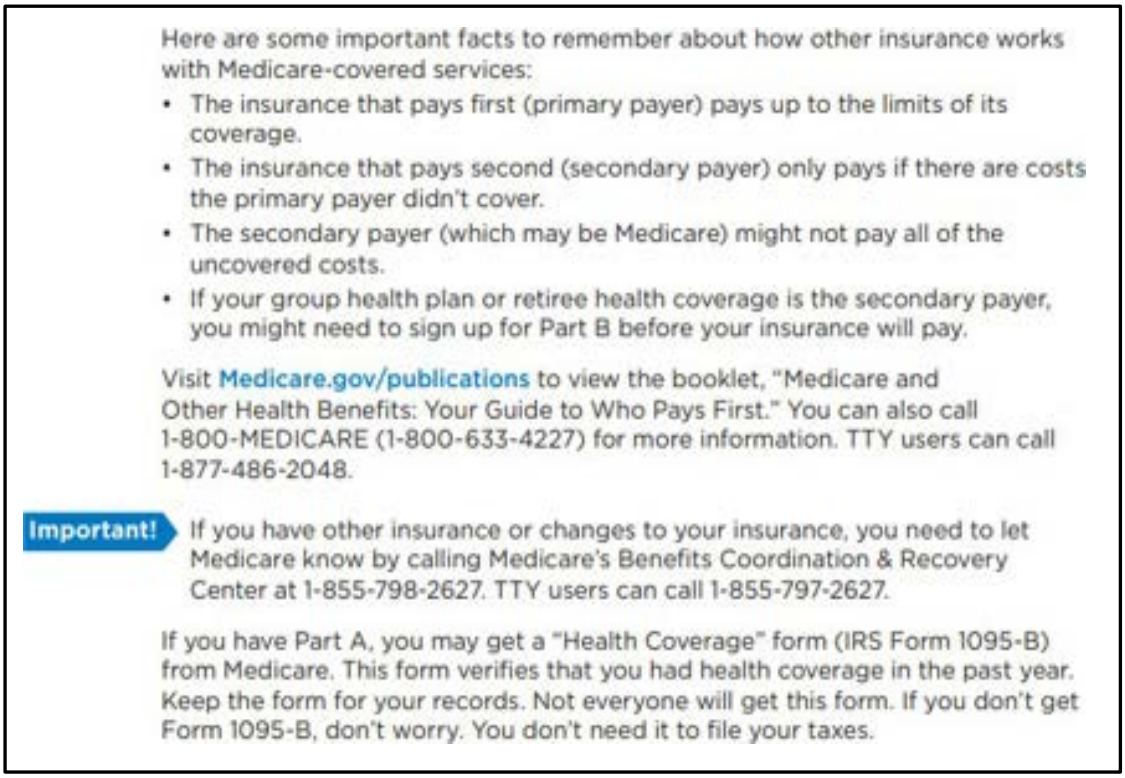
To determine when Medicare is primary see the excerpt below from https://www.medicare.gov/publications/10050-Medicare-and-You.pdf

How does my other insurance work with Medicare?

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

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

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



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

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

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

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

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

- For more information on Medicare and end stage renal disease (ESRD) see https://www.cms.gov/esrd-information-center .
- 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 benefit 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, the Plan 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 in Benefits Due to Other Entitlements

Surrogacy arrangements
If you enter into a Surrogacy Arrangement as a surrogate, you must pay us the amount of the charges for Covered Services you receive related to conception, pregnancy, delivery, or post-partum care relating to that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A Surrogacy Arrangement is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services; you will be credited any such payments toward the amount you must reimburse the Plan under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to the Plan your right to receive payments that are payable to you or any other payee under the Surrogacy

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

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

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

You must send all of this information to the following address:

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

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

If your Estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, your Estate, parent, guardian, or conservator and any settlement or judgment recovered by the Estate, parent, guardian, or conservator shall be subject to 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 its liens and other rights.

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

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

Covered Services from the following sources:

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

The Plan's Rights When Someone Caused or Is Responsible for Your Illness or Injury (Third Parties)

Rights to Subrogation and Reimbursement

The Plan has a right to subrogation and a right to reimbursement with respect to any amount you may or have a right to recover from someone you could or have sued. What this means is that, if your injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, the Plan has a legal claim on any amount you recover from the third party. These rights of the Plan can be enforced in a court of law.

References to "you" or "your" in this section shall include you, your Estate in the event of your death, and your heirs and beneficiaries, unless otherwise stated.

The right to subrogation applies when the Plan has paid benefits on your behalf for an injury or illness for which any third party is or may be responsible. The right to subrogation means the Plan can be substituted for you and can 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 is similar to subrogation. The right to reimbursement means that, if you receive or are entitled to receive a settlement, judgment, or other recovery from any third party as to whom it is alleged caused or is responsible for your illness or injury, you must use those proceeds from that settlement, judgment, or other recovery to fully return to the Plan 100% of the Plan benefits you received from the Plan. The right of reimbursement shall apply to any benefits received from the Plan at any time until the rights are extinguished, resolved or waived in writing.

The Plan is not required to help you to pursue your claim for damages or personal injuries.

If you do not abide by the terms of this Section, 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 the Plan has 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 the Plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

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 and you later are not covered by the Plan, the provisions of this Section continue to apply after you are no longer covered.

In the case of your death, the Plan's rights to subrogation and reimbursement 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.

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

KPIC is the Plan's delegate for the enforcement of its rights to subrogation and to reimbursement.

The Plan Administrator, as well as its agents and administrators administering the provisions of this Section, has the authority necessary to enforce compliance with the provisions of this Section. This authority includes the discretionary authority (1) to construe and enforce the terms of the Plan's subrogation and reimbursement rights, (2) to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan, and (3) to provide or exchange medical payment information with the responsible third party, your legal representatives, an insurer, the insurer's or responsible third party's legal representative, or other third party.

Who Are "Third Parties" Who May Be Responsible for Your Illness or Injury?

The following persons and entities are considered "third parties" for purposes of the Plan's rights of subrogation and reimbursement:

- 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.
- An employer in a workers' compensation case or other matter alleging workplace 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.

Your Enrollment in the Plan Means You Have Agreed the Terms of this Section

By enrolling in the Plan, you are bound by the terms in this Benefit Booklet, including this Section. Those terms include your obligation to cooperate with the Plan and KPIC in protecting the Plan's legal and equitable rights to subrogation and/or reimbursement in a timely manner, including, but not limited to:

- You are obligated to notify 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.
- You are obligated to provide any relevant information requested by KPIC.

- You are obligated to sign and/or deliver such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- You are obligated to respond to requests for information about any accident or injuries.
- You are obligated to make court appearances if requested by KPIC or the Plan..
- You are obligated to obtain the Plan's consent or the Plan's agent's consent before releasing any party from liability or payment of medical expenses.
- You are obligated to comply with the terms of this Section.
- You agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy – including no- fault benefits, PIP benefits and/or medical payment benefits – other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury.
- By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, and, through your enrollment in the Plan, you agree to this assignment voluntarily.

Your failure to cooperate as provided above would be a breach of contract. In such event, 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 the Plan has 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 its agents.

The Plan Has a Lien on Your Claims and Recoveries

The Plan's rights to reimbursement and subrogation create an "equitable lien by agreement" in favor of the Plan. This equitable lien by agreement attaches to your legal rights to sue the third parties who are legally liable or responsible for the injury or illness, as well as any amounts you actually recover.

The amount of the equitable lien by agreement is the total amount of the benefits paid by the Plan for medical services for the treatment of the injury or illness for which the third party is responsible and legally liable. Benefits paid by the Plan also include benefits advanced.

If you receive any payment from any party because of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and /or your representative are obligated to hold those funds in trust for the benefit of the Plan, either in a separate bank account in your name or in your representative's trust account.

The Plan's equitable lien by agreement is a first priority right to receive payment on any claim against a third party before you receive payment from that third party. The Plan's equitable lien by agreement is a first priority right on your recoveries that you receive from the third party.

The Plan's equitable lien by agreement 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, which assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's equitable lien by agreement attaches 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. For this purpose, recoveries include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages.

The Plan may assign its rights to enforce its equitable lien by agreement, as well as its other rights.

Legal Actions by the Plan

The Plan may, at its option, take necessary and appropriate action to enforce its rights under this Section. In particular, the Plan may file a lawsuit against you and others to recover the full amount of medical benefits you received for the illness or injury out of any settlement, judgment. or other recovery from any third party considered responsible. The Plan may also file suit in your name to recover the benefits paid (which would not obligate the Plan in any way to pay you part of any recovery the Plan might obtain except as provided by law).

The Plan may also file a lawsuit against your legal representatives if your legal representatives receive settlement or judgment proceeds on your behalf. Your legal representatives may be liable to the Plan for what the law calls "equitable relief" if they disburse settlement or judgment proceeds that they receive on your behalf without paying to the Plan the amount of recovery to which it is entitled.

In the case of your death giving rise to any wrongful death or survival claim, the Plan may file a lawsuit against your Estate, the personal representative of your Estate, and your heirs or beneficiaries.

Amount of the Plan's Lien

The amount of the Plan's lien is 100% of the Plan benefits you received from the Plan.

In addition, If the Plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

No amount of associated costs, including attorneys' fees, shall be deducted from the amount of the Plan's lien and what the Plan is entitled to recover 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 representatives 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.

The Plan's rights to recovery are not reduced due to your own negligence.

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.

What To Do If You Make a Claim or File a Lawsuit Against a Third Party

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 the following address:

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

For the Plan to determine the existence of any rights the Plan may have and to satisfy those rights, you must complete and send all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay the Plan directly.

If your Estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, this Section will apply your Estate, parent, guardian, or conservator and any settlement or judgment recovered by the Estate, parent, guardian, or conservator will be subject to the Plan's lien and other rights to the same extent as if you had asserted the claim against the third party.

You Must Not Settle Your Claim with the Third Parties Without the Plan's Approval

You may not agree to waive, release, or reduce the Plan's rights under this Section without the Plan's prior written consent. You may not accept any settlement that does not fully reimburse the Plan for what it has paid out in medical benefits for the illness or injury for which the third party is responsible, without the Plan's written consent.

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 the Kaiser Permanente representatives at most Network Facilities, or you can call Customer Services at the number on your ID card.

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

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

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

Grievances may be submitted in one of the following ways:

- at a Kaiser Permanente Facility (please refer to www.kp.org for addresses)
- by calling Customer Service at the number on the back of your ID card
- through www.kp.org

You will receive a confirmation letter within five days after receipt of your grievance. You will receive a written decision within 30 days after receipt of your grievance.

Note: If your issue is resolved to your satisfaction by the end of the next business day after your grievance is received orally, or at www.kp.org, and a Customer Services representative notifies you orally about the 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 that is adverse to you, 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, you may lose your opportunity for a review. Before you can file a lawsuit, you must meet any deadlines and exhaust the claims and appeals procedures set forth in this "Claims and Appeals" section. You do not, however, have to go through an External Review or a Voluntary Appeal to the Plan Administrator. For more information on filing a lawsuit, see the sections in this Benefit Booklet entitled "Contesting a Decision After a Complete or Partial Appeal Denial" and "Your Rights to File a Lawsuit."

There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

Timing of Claim Determinations

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

Determination on your claim will be made within the time frames indicated below based upon the type of claim: Urgent Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim.

An "Urgent Care Claim" is any claim for a Service with respect to which the application of the time periods for making non-urgent care determinations either (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services that are the subject of the claim, or a claim that your attending provider determines is urgent.

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

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

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

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

If you miss a deadline for filing a claim or appeal, review of your claim or appeals may be declined. Before you can file a civil action (lawsuit) under Section 502(a) of ERISA, you must meet any deadlines and exhaust the claims and appeals procedures set forth in this ""Claims and Appeals" section, unless the court finds some reason to excuse your compliance. There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

How to File a Claim

Network Providers are responsible for submitting claims for their Services on your behalf and will be paid directly by KPIC for the Services they render. If a Network Provider bills you for a Covered Service (other than for Cost Sharing), please call Customer Service at the telephone number listed in the "Customer Service Phone Numbers" section.

For Services rendered by Non-Network Providers, where the provider agrees to submit a claim on your behalf, eligible claims payment to the provider will require you to direct that benefit payment on your behalf be paid directly to the provider (assignment of benefits). Even if the Non-Network Provider agrees to bill on your behalf, you are responsible for making sure that the claim is received within 365 days of the date of Service and that all information necessary to process the claim is received.

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

Your claim must include all the following information:

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

To obtain a medical or pharmacy claim form, visit **www.kp.org,** log in, and go to *Billing*, then under *Claims & Costs* then select *Submit a Claim*. If KPIC pays a Post-Service Claim, it will pay you directly, except that it will pay the provider if your claim includes a written request to pay your benefits directly to the provider (assignment of benefits) or before the claim is processed, a written notice is received indicating you have assigned your right to payment to the provider.

If you have any questions about submitting a claim for payment for a Service from a Non-

Network Provider, please call customer Service at the telephone number listed on your ID card or in the "Customer Service Phone Numbers" section.

If a Claim Is Denied

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

- The reasons for the denial, including references to specific Plan provisions upon which the denial was based;
- If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why the information or materials are necessary;
- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- If the claim is denied based on a Medical Necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request;
- The notice will also state how and when to request a review of the denied claim,
- If applicable, the notice will also contain a statement of your right to bring a civil action (lawsuit) under Section 502(a) of ERISA of an adverse benefit determination following completion of all levels of review; and
- The availability of and contact information for any applicable office of health insurance consumer assistance ombudsman.

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

How to Appeal a Denied Claim

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

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

California	**Colorado**
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	**Mid-Atlantic (DC, MD, VA)**
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-888-225-7202
Northwest	**Washington**
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 Phone: 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Fax 1-206-630-1859 Phone 1-866-458-5479
Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	**Cigna Behavioral UM Appeals** Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the telephone:

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

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

Deemed Exhaustion of Appeal Process

If the Plan does not adhere to the Procedures on Appeals as described below, you will be treated as having exhausted the appeals process. This means that you are no longer required to stay within the mandated internal appeal process, but here is an important exception:

- The violation of the process did not cause and is not likely to cause prejudice or

harm; and
- There was good cause for the violation or the violation was due to matters beyond the control of the Plan; and
- The violation occurred in the context of an on-going, good faith exchange of information between the Plan and you.

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

Procedures on Appeal

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

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in the acknowledgement letter, sent to you within five days after your appeal is received. To arrange to give testimony by telephone, you should call the phone number mentioned in the acknowledgement letter. The information that you provide through testimony or other means will be added to your appeal file. That information will be reviewed without regard to whether this information was filed or considered in the initial decision regarding your request for Services.

Upon request and free of charge, you will be provided with 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 "Basic Plan Information" section. The individual acting for the Claims Fiduciary on the review will not be 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 Appeal Determinations

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

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 72 hours after receiving the appeal.	Not later than 30 days after receiving the appeal	Not later than 60 days after receiving the appeal.

* All listed time frames in "days" are calendar days

Notice of Determination on Appeal

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

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

- The reasons for the denial, including references to the specific Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, or because it is experimental, or due to 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 such explanation will be provided free of charge upon request.
- For Pre-Service Claims and Post-Service Claims, the notice will also state how and when to request a review of the denial of the initial appeal.
- For Urgent Care Claims, the notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures.
- The notice will also include a statement of your right to bring an action under Section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

Contesting a Decision After a Complete or Partial Appeal Denial

If, after exhausting the mandatory appeals process, you are still not satisfied with the decision on your claim, you still have rights to contest an adverse decision. Your remaining rights include the right to sue the Plan in court under Section 502(a) of ERISA.

You also have two voluntary dispute resolution options that you may wish to pursue before filing a lawsuit. These other options are (1) requesting an independent external review, and (2) making an appeal to the Reta Trust as Plan Administrator. Both of these voluntary options are discussed below.

External Review

If you are still dissatisfied you may have a right to request an external review by an independent third-party when the 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 the Plan is 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 an external review **must be filed within four months** after the date of receipt of a notice of an adverse benefit determination or second level 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 an adverse decision by the Claims Administrator, please submit your request in writing with the following information to the address below applicable to your Kaiser Region:

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

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	**Mid-Atlantic (DC, MD, VA)**
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 1-888-987-2252 Phone: 1-888-225-7202
Northwest	**Washington**
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 Phone: 1-866-616-0047	Kaiser Permanente Appeals P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone 1-866-458-5479 Fax: 1-206-630-1859
Cigna Providers Pre-Service Appeals – Not applicable to WA and NW members	
Cigna Medical UM Appeals Attn: Appeals P.O. Box 188062 Chattanooga, TN 37422-8062 Appeals Fax Number: 1-877-804-1679	**Cigna Behavioral UM Appeals** Attn: Appeals P.O. Box 23487 Chattanooga, TN 37422-3487 Appeals Fax Number: 1-855-816-3497

Or for Urgent appeals submitted over the phone, call:

Oral Appeal	If your employer has accepted Cigna, Providers Pre-Service Appeals – Not applicable to WA and NW members
1-800-788-0710 Or the number on the back of your Kaiser Permanente ID card	1-866-494-4872

Preliminary Review of the 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 the Utilization Review Accreditation Commission (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 may submit additional information that the IRO consider when conducting the external review. Additional information must be submitted in writing to the assigned IRO within ten business days following receipt of the notice. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, KPIC will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by KPIC to timely provide the documents and information will not delay the conduct of the external review. If KPIC fails to timely provide the documents and information, the assigned IRO may terminate the external review and 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, which were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under federal (or possibly state) law to either the

Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable ombudsman established under the PHS Act section 2793.

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

Reversal Of Plan's Decision on External Review

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 of the Expedited External Review Request

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

Referral To Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, KPIC will assign an IRO pursuant to the requirements set forth above for standard review. KPIC will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit

determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

Notice Of Final External Review Decision

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

Voluntary Appeal to the Reta Trust as Plan Administrator

As Plan Administrator, the Reta Trust has full power and authority to overturn a decision by the Claims Administrator if the Reta Trust determines that the decision of the Claims Administrator is contrary to the terms of the Plan.

Accordingly, if you have completed internal appeals process and you have received an adverse benefit determination from the Claims Administrator (KPIC), you may submit a request for reconsideration of the adverse benefit determination by way of a voluntary appeal to the Reta Trust as Plan Administrator. You may proceed with a voluntary appeal whether or not you have pursued the external review process. Furthermore, a designated representative, a provider, or an attorney may act on your behalf in a voluntary appeal.

A request for reconsideration as a voluntary appeal to the Plan Administrator should be submitted in writing to the following address:

Reta Trust
2121 California Street
Suite 350
Walnut Creek, CA 94596
Attn: Appeals

The Plan Administrator will have 90 days to decide your appeal, unless it determines that special circumstances require an extension of time. If an extension is required, the extension will be for no more than 90 days and the Plan Administrator will advise you of the need for the extension before the expiration of the initial 90-day period.

You may request a voluntary appeal at any time prior to the one-year deadline for filing a lawsuit discussed in the next section. If you do request a voluntary appeal and the time period for filing a lawsuit has not already expired, then the time period for you to file a lawsuit is suspended during the time the voluntary appeal is pending, but not less than 90 days.

Your Rights to File a Lawsuit; Your One-Year and Three-Year Deadlines

You have a right to bring a civil action under Section 502(a) of ERISA to contest an adverse benefit determination. You may bring the lawsuit in either state or federal court, although if you file the lawsuit in state court, the Plan may have it transferred to federal court.

No lawsuit or legal action of any kind related to a benefit decision, however, may be pursued by you, unless it is commenced within the earlier of the following:

- One year of the Claims Administrator's final decision on the claim or other request for benefits, or

- Three years after the date of the service or services that are the subject of your claim.

If the Plan decides that an internal appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date for the purpose of the one-year deadline..

A request for an External Review does **not** extend or suspend the one-year period for you to file a lawsuit.

If, however, you make a voluntary appeal to the Plan Administrator and the time period for filing a lawsuit has not already expired, then the time period for you to file a lawsuit is suspended during the time the voluntary appeal is pending, but not less than 90 days. This rule is designed to encourage the use of the voluntary appeal process if it has not already been used.

You must exhaust the Plan's internal Claims and Appeals procedure (before filing a lawsuit or taking other legal action of any kind against the Plan. If you do not, you may lose your right to have the court make a decision on your claim, unless the court excuses your failure for some reason. This rule does not apply to an External Review or a voluntary appeal to the Reta Trust as Plan Administrator. That is, you can still file a lawsuit even if you do not request an External Review or a voluntary appeal.

Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region

This section only applies to claims that are **not** claims for benefits under the Plan, such as by way of example medical or hospital malpractice or premises liability.

This "Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region" section applies only to Participants and Dependents who are assigned to a Kaiser Permanente California Region.

For all claims subject to this "Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration.

Scope of Arbitration
Any dispute shall be submitted to binding arbitration if all the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to a Participant or Dependent Party's relationship to the Kaiser Permanente or KPIC as a Participant or Dependent, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical Services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of Services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Participant or Dependent Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Participant or Dependent Parties
- The claim is *not* within the jurisdiction of the Small Claims Court
- The claim is *not* a claim for benefits or other benefit-related request that can be enforced by a lawsuit filed pursuant to Section 502(a)(1)(B) of ERISA.

As referred to in this "Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region" section, "Participant or Dependent Parties" include:

- A Participant or Dependent
- A Participant's or Dependent's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a Participant's or Dependent's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Permanente Insurance Company (KPIC)
- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals (KFH)
- KP Cal, LLC (KP Cal)
- The Permanente Medical Group, Inc. (TPMG)
- Southern California Permanente Medical Group (SCPMG)
- The Permanente Federation, LLC

- The Permanente Company, LLC
- Any KFH, TPMG, or SCPMG physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Participant or Dependent Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Participant or Dependent Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Participant or Dependent Party or a Kaiser Permanente Party against whom a claim is asserted.

Initiating Arbitration
Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration
KPIC, Kaiser Foundation Health Plan, Inc., KFH, KP Cal, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of one of the following:

If the claim relates to a Participant or Dependent who is assigned to the Kaiser Permanente Northern California Region:

Kaiser Foundation Health Plan, Inc.
Legal Department
One Kaiser Plaza
Oakland, CA 94612

If the claim relates to a Participant or Dependent who is assigned to the Kaiser Permanente Southern California Region:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed complete when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee
The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for

Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Customer Service at the telephone number listed on your ID card.

Number of Arbitrators
The number of Arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two-party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of Arbitrators' Fees and Expenses
Kaiser Foundation Health Plan, Inc. will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") http://www.oia-kaiserarb.com/. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs
Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this “Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region” section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure
Arbitrations shall be conducted per the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Customer Service at the telephone number listed in the “Customer Service Phone Numbers”.
General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region" section.

In accord with the rule that applies under sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration for Participants and Dependents Assigned to a Kaiser Permanente California Region" section shall not be denied, stayed, or otherwise impeded because a dispute between a Participant or Dependent Party and a Kaiser Permanente Party involves both arbitrable and non-arbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Arbitration Agreement for Participants and Dependents Assigned to the Kaiser Permanente Northern California Region or Southern California Region

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure**,** and certain benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical Services were unnecessary or unauthorized or were improperly, negligently, or

incompetently rendered), for premises liability, or relating to the delivery of Services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in Benefit Booklet.

Termination or Loss of Coverage

Termination of Coverage Due to Loss of Eligibility

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

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

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

Termination will be effective on the date notice is sent. All rights cease as of the date of termination.

Continuation of Coverage After Loss of Normal Coverage

COBRA Continuation Coverage

This summary contains important information about the rights of Participants and Dependents to COBRA continuation coverage, which is a temporary extension of coverage under the Plan after certain types of losses of normal of coverage. Your right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The types of losses of coverage that trigger your right to COBRA continuation coverage include losses resulting from one or more of the following events:

(1) A termination of employment of the Participant (other than for gross misconduct)
(2) A reduction in hours of the Participant
(3) The death of the Participant
(4) The enrollment of the Participant in Medicare
(5) Loss of eligibility of a Dependent spouse by reason of divorce from the Participant
(6) Loss of eligibility as a Dependent child, such as by attaining age 26.

Important information on the rules governing eligibility for continuation coverage under COBRA and how long the temporary coverage lasts is found in the Summary Plan Description for the Reta Plan. You should make sure you have a copy of the Summary Plan Description. Contact your Employer for information as to how to obtain a copy of the Summary Plan Description.

Other Continuation of Coverage Rights (USERRA and FMLA)

You may be entitled to continue coverage under the Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) if you go on a qualifying U.S. military leave of absence/

You may also be entitled to continue coverage under the Plan if you take leave under the federal Family and Medical Leave Act (FMLA).

Important information on the rules governing eligibility for continuation coverage under USERRA or FMLA and how long the temporary coverage lasts is found in the Summary Plan Description for the Reta Plan. You should make sure you have a copy of the Summary Plan Description. Contact your Employer for information as to how to obtain a copy of the Summary Plan Description.

Continuity of Care: Your Eligibility for Transitional Care

The Plan uses Network providers to provide Plan benefits. Should a Network Provider contract terminate, Continuing Care Patients of the terminated provider have a right to elect to continue transitional care from the terminated provider under the same terms and conditions after the termination of the contract.
Transitional care may also be available if the Plan Sponsor terminates its contract with the Claims Administrator and contracts with a new third-party administrator (TPA) that does not include in its network the provider that is providing your care.

Transitional care may also be available if your Employer and the Plan Sponsor terminate your Employer's participation in the Plan and the provider that is providing your care is not included in a network under your Employer's new group health plan.

If you are a Continuing Care Patient and eligible for transitional care, you may receive care from the provider providing your care for up to 90 days from the date of receipt of notice of termination or until you are no longer a Continuing Care Patient, whichever is earlier.

A Continuing Care Patient is an individual who, with respect to a provider:

a) Is undergoing a course of treatment for a serious and complex condition from the provider or facility; or
b) Is undergoing a course of institutional or inpatient care from the provider or facility; or
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; or
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

Recovery of Overpayments

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.

Important Legal Notices

Important legal notices are found in the Summary Plan Description for the Reta Plan. You should make sure you have a copy of the Summary Plan Description. Contact your Employer for information as to how to obtain a copy of the Summary Plan Description.

Service Areas

Participants must live or work in a Kaiser Permanente Service Area at the time of enrollment. You cannot continue enrollment as a Participant if you move outside a Kaiser Permanente Service Area. To verify the Kaiser Permanente Service Area for your zip code, visit the following webpage:

https://individual-family.kaiserpermanente.org/healthinsurance

Service Areas for California

NORTHERN CALIFORNIA	
County	**City**
ALAMEDA	ALAMEDA, ALBANY, BERKELEY, CASTRO VALLEY, DUBLIN, EMERYVILLE, FREMONT, HAYWARD, LIVERMORE, NEWARK, OAKLAND, PIEDMONT, PLEASANTON, SAN LEANDRO, SAN LORENZO, SUNOL, UNION CITY
AMADOR	IONE, PLYMOUTH
CONTRA COSTA	ALAMO, ANTIOCH, BETHEL ISLAND, BRENTWOOD, BYRON, CANYON, CLAYTON, CONCORD, CROCKETT, DANVILLE, DIABLO, DISCOVERY BAY, EL CERRITO, EL SOBRANTE, HERCULES, KNIGHTSEN, LAFAYETTE, MARTINEZ, MORAGA, OAKLEY, ORINDA, PINOLE, PITTSBURG, PLEASANT HILL, PORT COSTA, RICHMOND, RODEO, SAN PABLO, SAN RAMON, WALNUT CREEK
EL DORADO	COLOMA, COOL, DIAMOND SPRINGS, EL DORADO, EL DORADO HILLS, GARDEN VALLEY, GEORGETOWN, GREENWOOD, LOTUS, PILOT HILL, PLACERVILLE, RESCUE, SHINGLE SPRINGS
FRESNO	AUBERRY, BIOLA, BURREL, CARUTHERS, CLOVIS, DEL REY, FIVE POINTS, FOWLER, FRESNO, FRIANT, HELM, KERMAN, KINGSBURG, LATON, ORANGE COVE, PARLIER, PIEDRA, PRATHER, RAISIN CITY, REEDLEY, RIVERDALE, SAN JOAQUIN, SANGER, SELMA, SQUAW VALLEY, TOLLHOUSE, TRANQUILITY
KINGS	HANFORD
MADERA	AHWAHNEE, BASS LAKE, COARSEGOLD, MADERA, NORTH FORK, O NEALS, OAKHURST, RAYMOND, WISHON
MARIN	BELVEDERE TIBURON, BOLINAS, CORTE MADERA, DILLON BEACH, FAIRFAX, FOREST KNOLLS, GREENBRAE, INVERNESS, KENTFIELD, LAGUNITAS, LARKSPUR, MARSHALL, MILL VALLEY, NICASIO, NOVATO, OLEMA, POINT REYES STATION, ROSS, SAN ANSELMO, SAN GERONIMO, SAN QUENTIN, SAN RAFAEL, SAUSALITO, STINSON BEACH, TOMALES, WOODACRE
MARIPOSA	FISH CAMP, LA GRANGE
MERCED	GUSTINE
NAPA	AMERICAN CANYON, ANGWIN, CALISTOGA, DEER PARK, NAPA, OAKVILLE, POPE VALLEY, RUTHERFORD, SAINT HELENA, YOUNTVILLE
PLACER	APPLEGATE, AUBURN, GRANITE BAY, LINCOLN, LOOMIS, MEADOW VISTA, NEWCASTLE, PENRYN, ROCKLIN, ROSEVILLE, SHERIDAN, WEIMAR
SACRAMENTO	ANTELOPE, CARMICHAEL, CITRUS HEIGHTS, COURTLAND, ELK GROVE, ELVERTA, FAIR OAKS, FOLSOM, GALT, HERALD, HOOD, ISLETON, MATHER, MCCLELLAN, NORTH HIGHLANDS, ORANGEVALE, RANCHO CORDOVA, REPRESA, RIO LINDA, RYDE, SACRAMENTO, SLOUGHHOUSE, WALNUT GROVE, WILTON
SAN FRANCISCO	SAN FRANCISCO
SAN JOAQUIN	ACAMPO, CLEMENTS, ESCALON, FARMINGTON, FRENCH CAMP, HOLT, LATHROP, LINDEN, LOCKEFORD, LODI, MANTECA, RIPON, SAN JOAQUIN, STOCKTON, THORNTON, TRACY, VICTOR, WOODBRIDGE
SAN MATEO	ATHERTON, BELMONT, BRISBANE, BURLINGAME, DALY CITY, EL GRANADA, HALF MOON BAY, LA HONDA, LOMA MAR, MENLO PARK, MILLBRAE, MONTARA, MOSS BEACH, PACIFICA, PESCADERO, PORTOLA VALLEY, REDWOOD CITY, SAN BRUNO, SAN CARLOS, SAN FRANCISCO, SAN GREGORIO, SAN MATEO, SOUTH SAN FRANCISCO

SANTA CLARA	ALVISO, CAMPBELL, COYOTE, CUPERTINO, GILROY, HOLY CITY, LOS ALTOS, LOS GATOS, MILPITAS, MORGAN HILL, MOUNT HAMILTON, MOUNTAIN VIEW, NEW ALMADEN, PALO ALTO, REDWOOD ESTATES, SAN JOSE, SAN MARTIN, SANTA CLARA, SARATOGA, STANFORD, SUNNYVALE
SANTA CRUZ	APTOS, BEN LOMOND, BOULDER CREEK, BROOKDALE, CAPITOLA, DAVENPORT, FELTON, FREEDOM, MOUNT HERMON, SANTA CRUZ, SCOTTS VALLEY, SOQUEL, WATSONVILLE
SOLANO	BENICIA, BIRDS LANDING, DIXON, ELMIRA, FAIRFIELD, RIO VISTA, SUISUN CITY, TRAVIS AFB, VACAVILLE, VALLEJO
SONOMA	BODEGA, BODEGA BAY, BOYES HOT SPRINGS, CAMP MEEKER, CAZADERO, CLOVERDALE, COTATI, DUNCANS MILLS, EL VERANO, ELDRIDGE, FORESTVILLE, FULTON, GEYSERVILLE, GLEN ELLEN,

	GRATON, GUERNEVILLE, HEALDSBURG, JENNER, KENWOOD, MONTE RIO, OCCIDENTAL, PENNGROVE, PETALUMA, RIO NIDO, ROHNERT PARK, SANTA ROSA, SEBASTOPOL, SONOMA, VALLEY FORD, VILLA GRANDE, VINEBURG, WINDSOR
STANISLAUS	CERES, CROWS LANDING, DENAIR, EMPIRE, HICKMAN, HUGHSON, KEYES, MODESTO, NEWMAN, OAKDALE, PATTERSON, RIVERBANK, SALIDA, TURLOCK, VERNALIS, WATERFORD, WESTLEY
SUTTER	KNIGHTS LANDING, NICOLAUS, PLEASANT GROVE, RIO OSO, ROBBINS SACRAMENTO
TULARE	DINUBA, SULTANA, TRAVER
YOLO	CAPAY, CLARKSBURG, DAVIS, SACRAMENTO, WEST SACRAMENTO, WINTERS, WOODLAND, YOLO, ZAMORA
YUBA	BEALE AFB, OLIVEHURST, WHEATLAND
SOUTHERN CALIFORNIA	
KERN	ARVIN, BAKERSFIELD, BODFISH, BUTTONWILLOW, CALIENTE, CALIFORNIA CITY, CANTIL, DELANO, EDISON, FELLOWS, FRAZIER PARK, GLENNVILLE, KEENE, KERNVILLE, LAKE ISABELLA, LAMONT, LOST HILLS, MARICOPA, MC FARLAND, MC KITTRICK, MOJAVE, PINE MOUNTAIN CLUB, ROSAMOND, SHAFTER, TAFT, TEHACHAPI, TUPMAN, WASCO, WOFFORD HEIGHTS, WOODY
LOS ANGELES	ACTON, AGOURA HILLS, ALHAMBRA, ALTADENA, ARCADIA, ARTESIA, AZUSA, BALDWIN PARK, BELL, BELL GARDENS, BELLFLOWER, BEVERLY HILLS, BURBANK, CALABASAS, CANOGA PARK, CANYON COUNTRY, CARSON, CASTAIC, CERRITOS, CHATSWORTH, CITY OF INDUSTRY, CLAREMONT, COMPTON, COVINA, CULVER CITY, DIAMOND BAR, DODGERTOWN, DOWNEY, DUARTE, EL MONTE, EL SEGUNDO, ENCINO, GARDENA, GLENDALE, GLENDORA, GRANADA HILLS, HACIENDA HEIGHTS, HARBOR CITY, HAWAIIAN GARDENS, HAWTHORNE, HERMOSA BEACH, HUNTINGTON PARK, INGLEWOOD, LA CANADA FLINTRIDGE, LA CRESCENTA, LA MIRADA, LA PUENTE, LA VERNE, LAKE HUGHES, LAKEWOOD, LANCASTER, LAWNDALE, LEBEC, LITTLEROCK, LLANO, LOMITA, LONG BEACH, LOS ANGELES, LYNWOOD, MALIBU, MANHATTAN BEACH, MARINA DEL REY, MAYWOOD, MISSION HILLS, MONROVIA, MONTEBELLO, MONTEREY PARK, MONTROSE, MOUNT WILSON, NEWHALL, NORTH HILLS, NORTH HOLLYWOOD, NORTHRIDGE, NORWALK, PACIFIC PALISADES, PACOIMA, PALMDALE, PALOS VERDES PENINSULA, PANORAMA CITY, PARAMOUNT, PASADENA, PEARBLOSSOM, PICO RIVERA, PLAYA DEL REY, PLAYA VISTA, POMONA, PORTER RANCH, RANCHO PALOS VERDES, REDONDO BEACH, RESEDA, ROSEMEAD, ROWLAND HEIGHTS, SAN DIMAS, SAN FERNANDO, SAN GABRIEL, SAN MARINO, SAN PEDRO, SANTA CLARITA, SANTA FE SPRINGS, SANTA MONICA, SHERMAN OAKS, SIERRA MADRE, SIGNAL HILL, SOUTH EL MONTE, SOUTH GATE, SOUTH PASADENA, STEVENSON RANCH, STUDIO CITY, SUN VALLEY, SUNLAND, SYLMAR, TARZANA, TEMPLE CITY, TOLUCA LAKE, TOPANGA, TORRANCE, TUJUNGA, UNIVERSAL CITY, VALENCIA, VALLEY VILLAGE, VALYERMO, VAN NUYS, VENICE, VERDUGO CITY, WALNUT, WEST COVINA, WEST HILLS, WEST HOLLYWOOD, WHITTIER, WILMINGTON, WINNETKA, WOODLAND HILLS

ORANGE	ALISO VIEJO, ANAHEIM, ATWOOD, BREA, BUENA PARK, CAPISTRANO BEACH, CORONA DEL MAR, COSTA MESA, CYPRESS, DANA POINT, EAST IRVINE, EL TORO, FOOTHILL RANCH, FOUNTAIN VALLEY, FULLERTON, GARDEN GROVE, HUNTINGTON BEACH, IRVINE, LA HABRA, LA PALMA, LADERA RANCH, LAGUNA BEACH, LAGUNA HILLS, LAGUNA NIGUEL, LAGUNA WOODS, LAKE FOREST, LOS ALAMITOS, MIDWAY CITY, MISSION VIEJO, NEWPORT BEACH, NEWPORT COAST, ORANGE, PLACENTIA, RANCHO SANTA MARGARITA, SAN CLEMENTE, SAN JUAN CAPISTRANO, SANTA ANA, SEAL BEACH, SILVERADO, STANTON, SUNSET BEACH, SURFSIDE, TRABUCO CANYON, TUSTIN, VILLA PARK, WESTMINSTER, YORBA LINDA
RIVERSIDE	BANNING, BEAUMONT, CABAZON, CALIMESA, CATHEDRAL CITY, COACHELLA, CORONA, DESERT HOT SPRINGS, HEMET, HOMELAND, INDIAN WELLS, INDIO, LA QUINTA, LAKE ELSINORE, MARCH AIR RESERVE BASE, MECCA, MENIFEE, MIRA LOMA, MORENO VALLEY, MURRIETA, NORCO, NORTH PALM SPRINGS, NUEVO, PALM DESERT, PALM SPRINGS, PERRIS, QUAIL VALLEY, RANCHO MIRAGE, RIVERSIDE, SALTON CITY, SAN JACINTO, SUN CITY, TEMECULA, THERMAL, THOUSAND PALMS, WHITEWATER, WILDOMAR, WINCHESTER
SAN BERNARDINO (Partial County)	ANGELUS OAKS, APPLE VALLEY, BIG BEAR CITY, BIG BEAR LAKE, BLOOMINGTON, BLUE JAY, BRYN MAWR, CEDAR GLEN, CEDARPINES PARK, CHINO, CHINO HILLS, COLTON, CREST PARK, CRESTLINE, FAWNSKIN, FONTANA, FOREST FALLS, GRAND TERRACE, GREEN VALLEY LAKE, GUASTI, HESPERIA, HIGHLAND, JOSHUA TREE, LAKE ARROWHEAD, LANDERS, LOMA LINDA, LYTLE CREEK, MENTONE, MONTCLAIR, MORONGO VALLEY, MT BALDY, ONTARIO, PATTON, PHELAN, PINON HILLS, PIONEERTOWN, RANCHO CUCAMONGA, REDLANDS, RIALTO, RIMFOREST, RUNNING SPRINGS, SAN BERNARDINO, SKYFOREST, SUGARLOAF, TWENTYNINE PALMS, TWIN PEAKS, UPLAND, VICTORVILLE, WRIGHTWOOD, YUCAIPA, YUCCA VALLEY
SAN DIEGO (Partial County)	ALPINE, BONITA, BONSALL, CAMP PENDLETON, CARDIFF BY THE SEA, CARLSBAD, CHULA VISTA, CORONADO, DEL MAR, DESCANSO, DULZURA, EL CAJON, ENCINITAS, ESCONDIDO, FALLBROOK, GUATAY, IMPERIAL BEACH, JAMUL, LA JOLLA, LA MESA, LAKESIDE, LEMON GROVE, NATIONAL CITY, OCEANSIDE, PALA, PALOMAR MOUNTAIN, PAUMA VALLEY, PINE VALLEY, POTRERO, POWAY, RAMONA, RANCHO SANTA FE, SAN DIEGO, SAN LUIS REY, SAN MARCOS, SAN YSIDRO, SANTEE, SOLANA BEACH, SPRING VALLEY, TECATE, VALLEY CENTER, VISTA, WARNER SPRINGS
TULARE	RICHGROVE
VENTURA (Partial County)	BRANDEIS, CAMARILLO, FILLMORE, MOORPARK, NEWBURY PARK, OAK PARK, OAK VIEW, OXNARD, PIRU, POINT MUGU NAWC. PORT HUENEME, PORT HUENEME CBC BASE, SANTA PAULA, SIMI VALLEY, SOMIS, THOUSAND OAKS, VENTURA, WESTLAKE VILLAGE

Service Areas for the Northwest

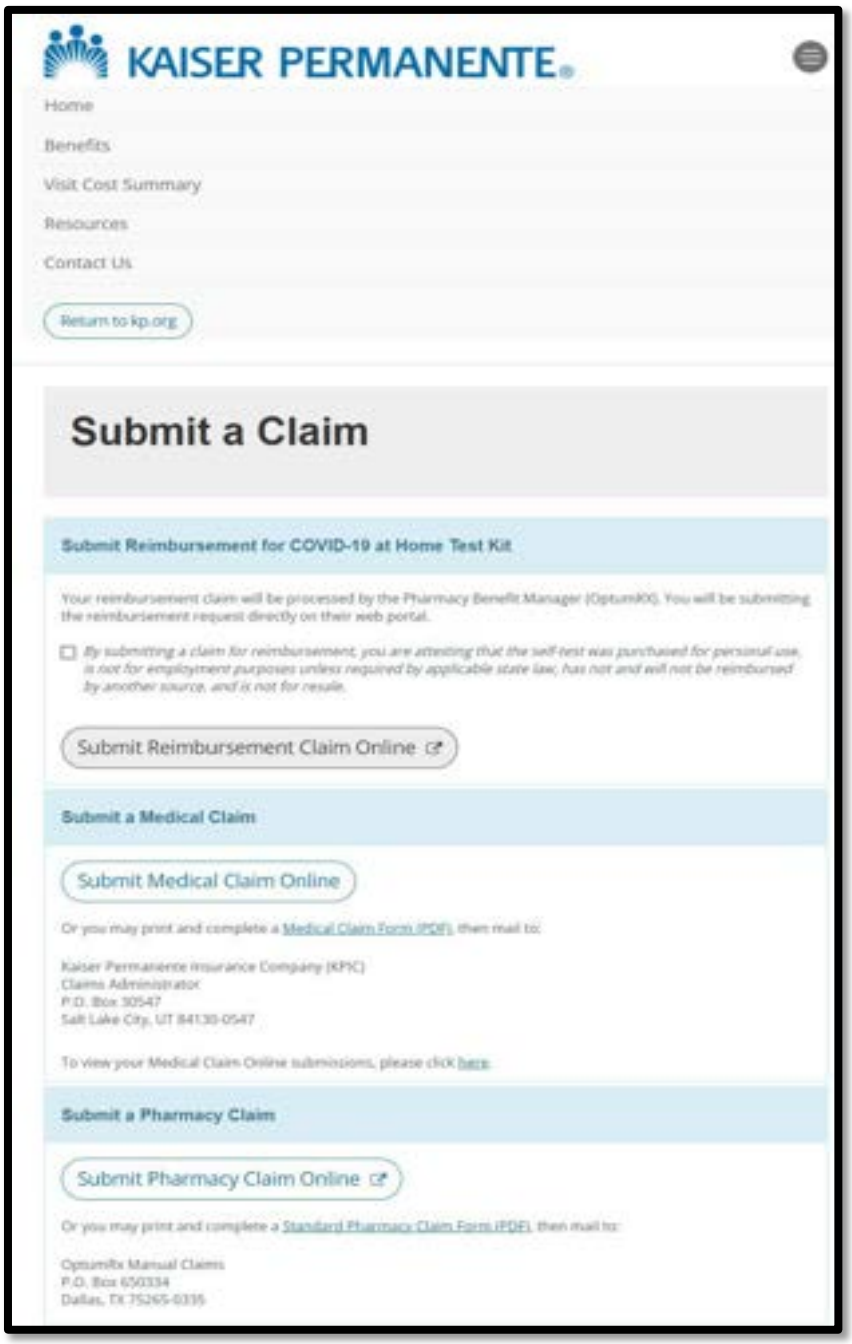
COUNTY	CITY	STATE
BENTON	CORVALLIS, PHILOMATH	OR
CLACKAMAS	BEAVERCREEK, BORING, BRIGHTWOOD, CANBY, CLACKAMAS, COLTON, EAGLE CREEK, ESTACADA, GLADSTONE, HAPPY VALLEY, LAKE OSWEGO, MARYLHURST, MOLALLA, MULINO, OREGON CITY, PORTLAND, RHODODENDRON, SANDY, WELCHES, WEST LINN, WILSONVILLE	OR
COLUMBIA	CLATSKANIE, COLUMBIA CITY, DEER ISLAND, RAINIER, SAINT HELENS, SCAPPOOSE, VERNONIA, WARREN	OR
HOOD RIVER	CASCADE LOCKS	OR
LINN	ALBANY, CRABTREE, LEBANON, LYONS, MILL CITY, SCIO, TANGENT	OR
MARION	AUMSVILLE, AURORA, DETROIT, DONALD, GATES, GERVAIS, HUBBARD, JEFFERSON, KEIZER, MEHAMA, MOUNT ANGEL, SAINT BENEDICT, SAINT PAUL, SALEM, SCOTTS MILLS, SILVERTON, STAYTON, SUBLIMITY, TURNER, WOODBURN	OR

MULTNOMAH	BRIDAL VEIL, CORBETT, FAIRVIEW, GRESHAM, PORTLAND, TROUTDALE	OR
POLK	DALLAS, FALLS CITY, INDEPENDENCE, MONMOUTH, RICKREALL, SALEM	OR
WASHINGTON	ALOHA, BANKS, BEAVERTON, BUXTON, CORNELIUS, FOREST GROVE, GALES CREEK, GASTON, HILLSBORO, MANNING, NORTH PLAINS, PORTLAND, SHERWOOD, TIMBER, TUALATIN	OR
YAMHILL	AMITY, CARLTON, DAYTON, DUNDEE, GRAND RONDE, LAFAYETTE MCMINNVILLE, NEWBERG, SHERIDAN, WILLAMINA, YAMHILL	OR
CLARK	AMBOY, BATTLE GROUND, BRUSH PRAIRIE, CAMAS, HEISSON, LA CENTER, RIDGEFIELD, VANCOUVER, WASHOUGAL, YACOLT	WA
COWLITZ	ARIEL, CARROLLS, CASTLE ROCK, COUGAR, KALAMA, KELSO, LONGVIEW, RYDERWOOD, SILVERLAKE, TOUTLE, WOODLAND	WA
LEWIS	TOLEDO, VADER, WINLOCK	WA
SKAMANIA	NORTH BONNEVILLE, STEVENSON	WA
WAHKIAKUM	CATHLAMET, SKAMOKAWA	WA

Other Helpful Information

Submitting a Claim

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



Non-Discrimination Notice

Non-Discrimination Notice

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

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

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

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

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

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

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

Consumer Assistance Tools

Help In Your language:

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

KPIC:

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

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

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

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

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

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

Bàsɔ-Wùdù (Bassa) DYÉĐÉ-GBO-DÉ-ĐÈ: Ɔ jū ké m̀ dyi Bàsɔ-Wùdù po-nyɔ́ jūin, wudu-xwiniin mú zàzà bē kè gbo-kpá-kpá ɔ kè kûà tɔ̀ɔ́ bē se widi. péè-péè dò kɔ̂ɛɛ ni bó m̀ bii. Đá **1-866-213-3062** (TTY: **711**).

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

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

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

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

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

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

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

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

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

Igbo (Igbo) Gee ntị: O bụrụ na ịna-asụ asụsụ English, ọrụ enyemaka asụsụ gụnyere ọrụ na enyemaka kwesịrị ekwesị, dị n'efu, dị maka gị. Kpọọ **1-866-213-3062** (TTY: **711**).

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

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

ខ្មែរ (Khmer) សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសារួមទាំងឧបករណ៍ និងសេវាកម្មជំនួយសមរម្យ ដោយមិនគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរសព្ទទៅលេខ **1-866-213-3062** (TTY: **711**)។

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

ພາສາວາວ (Laotian) ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາວາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາລວມທັງຄວາມຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມທີກ່ຽວຂ້ອງໂດຍບໍ່ເສຍຄ່າ. ໂທຫາ **1-866-213-3062** (TTY: **711**).

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

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

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

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

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

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

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

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

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

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

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

اردو(Urdu) توجہ دیں: اگر آپ اردو بولتے ہیں تو لسانی اعانت کی خدمات، بشمول مناسب معاون امدادی آلات اور خدمات، بلا معاوضہ، آپ کے لیے دستیاب ہیں۔ **1-866-213-30621** (TTY: **711**) پر کال کریں۔

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

Yorùbá (Yoruba) ÀKÍYÈSÍ: Bí o bá lè sọ èdè Yorùbá, àwọn ètò ìrànlọ́wọ́ èdè, títí kan àwọn ohun èlò àti isẹ́ ìrànlọ́wọ́ tó yẹ wà fún ọ lófẹ̀ẹ́. Pe **1-866-213-3062** (TTY: **711**).

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, please refer to the identical heading in the "Benefits and Cost Sharing" section. See also the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section.

IN SUMMARY: In order for the Plan to pay benefits, a Service must meet all of the following criteria: (1) be Medically Necessary; (2) meet the requirements for coverage as described in this Benefit Booklet; (3) be shown as a Covered Service in this "Schedule of Benefits"; (4) not be on the list of exclusions in the "Exclusions: Services and Treatments That Are Not Covered by the Plan" section; and (5) be consistent with the Ethical and Religious Directives. Plan benefits may then be limited or reduced under the rules in the "General Limitations, Coordination of Benefits, and Reductions" section.

OVERALL PLAN FEATURES	
Plan Accumulation Type	**Calendar Year**
Annual Out-of-Pocket Maximum	
Individual	**$1,500**
Family	**$3,000**
The Out-of-Pocket Maximum 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 Maximum has been met.	
Out-of-Pocket Maximum Carry Over	**No**
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	Applies to OOP
Wellness Exams – Adults (Including *Well Woman*)	**$0**	**No**
Wellness Exams – Children	**$0**	**No**
Preventive Screenings	**$0**	**No**
Immunizations (Preventive) Adults and Children.	**$0**	**No**
Health Education and Self-Management Classes	**$0**	**No**

OUTPATIENT SERVICES (Office, Outpatient Facility/Clinics, or any Non-Inpatient Setting)

Primary Care Cost Sharing will be charged for Family Practice, General Internal Medicine and General Pediatrics specialties. Specialty Care Cost Sharing will be charged for visits with all other medical specialties except, non-physician providers and 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	Applies to OOP
Office Visits	**$25**	**Yes**
Referred Hospital Clinic Visits		
Provider	**$25**	**Yes**
Facility Clinic Charges	**$0**	**Yes**
Telemedicine Telephone, Video, or Chat/Online communications	**$0**	**Yes**
Allergy Office visit cost share may apply		
Injection	**$5**	**Yes**
Testing	**$25**	**Yes**
Serum only	**$0**	**Yes**
Biofeedback Services Medical and Mental Health Services	**$25**	**Yes**
Cardiac Rehab	**$25**	**Yes**
Chemotherapy Services	**$0**	**Yes**

OUTPATIENT SERVICES (Office, Outpatient Facility/Clinics, or any Non-Inpatient Setting) continued		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Dialysis Services		
Routine Nephrologist visit	**$0**	**Yes**
Non-routine Nephrology visit	**$25**	**Yes**
Home Dialysis	**$0**	**Yes**
Family Planning		
Counseling and instruction in natural family planning	**$0**	**No**
All other family planning services	**NOT COVERED**	**N/A**
Implantable or injectable contraceptives	**NOT COVERED**	**N/A**
Male Sterilization	**NOT COVERED**	**N/A**
Hearing Exam Audiometry exam	**$0**	**No**
House Calls	**$0**	**Yes**
Infusion Services Requires skilled or medical administration, Office visit cost share may apply		
Infusion	**$0**	**Yes**
Home Infusion Infusion materials, drugs and supplies	**$0**	**Yes**
Injections and Immunizations Non-routine, Office visit cost share may apply		
Injection	**$0**	**Yes**
Travel Immunizations Office visit cost share may apply		
Injection	**$0**	**Yes**
Nutrition Counseling		
Office Visit	**$25**	**Yes**
Group visit	**$12**	**Yes**
Radiation Therapy	**$0**	**Yes**
Pulmonary Therapy	**$25**	**Yes**
Respiratory Therapy	**$25**	**Yes**
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process.		
UV Light Therapy (in the Office) Office Visit Cost Sharing may apply)	**$0**	**Yes**
UV Light Therapy Box (for Home Use)	**20%**	**Yes**
Vision Exam	**$0**	**No**
NOTE: Medical care for eye illness or injury are covered under the Medical benefit by provider specialty.		

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums	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	**$250**	**Yes**
Ambulance		
Emergency Ground and Air Ambulance	**$50**	**Yes**
Scheduled Ground and Air Ambulance	**$50**	**Yes**
Non-Network or Network Hospital to Network Hospital (repatriation)	**No charge**	**Yes**
Emergency Services Accident and Illness. No charge for same day/same condition visits.	**$100**	**Yes**
Copay waived if admitted	**Yes**	**N/A**
Urgent and After-Hours Care Urgent Care and After-Hours settings	**$25**	**Yes**
Outpatient Surgery	**$25**	**Yes**
Abortion	**NOT COVERED**	**N/A**
Bariatric Surgery		
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center	**$25**	**Yes**
Inpatient Hospital per admission	**$250**	**Yes**
Temporomandibular Surgery (TMD/TMJ)		
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center	**$25**	**Yes**
Inpatient Hospital per admission	**$250**	**Yes**

MATERNITY

Includes most Routine Pre-Natal and Post-Partum care. Delivery charges and Non-routine Maternity Care and Routine Care not included under Preventive Care would be covered at the appropriate cost share.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Routine Pre-Natal and Post-Partum Care		
Pre-natal and post-partum visits	**$0**	**No**
Hospital Inpatient Includes Contracted Birthing Center if available		
Per admission (facility) Includes Well baby facility fees when billed with mother	**$250**	**Yes**
Well Newborn	**$0**	**Yes**

DIAGNOSTIC TESTS & PROCEDURES

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

Benefit Type	You Pay and/or Maximums	Applies to OOP
Diagnostic Lab and X-ray	**$0**	**Yes**
Special Procedures	**$0**	**Yes**
High Tech/Advanced Radiology - CT, MRI, and PET	**$0**	**Yes**

FERTILITY SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Hospital Charges	**NOT COVERED**	**N/A**
Office Visit	**NOT COVERED**	**N/A**
Diagnostic Lab and X-ray	**NOT COVERED**	**N/A**
Outpatient Hospital or Ambulatory Surgery Center	**NOT COVERED**	**N/A**

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Mental Health - Inpatient		
Per admission	**$250**	**Yes**
Residential Treatment		
Per admission	**$250**	**Yes**
Partial Hospitalization		
Per visit	**$0**	**Yes**
Mental Health - Intensive Outpatient Includes all Services provided during the day	**$0**	**Yes**
Mental Health – Outpatient/Office		
Individual Visit	**$25**	**Yes**
Group Visit	**$12**	**Yes**
Substance Use Disorder Services – Inpatient Detox covered under medical benefits		
Per admission	**$250**	**Yes**
Residential Treatment		
Per admission	**$250**	**Yes**
Substance Use Disorder Services - Day Treatment /Intensive Outpatient, per day Includes all Services provided during the day	**$5**	**Yes**
Substance Use Disorder Services – Outpatient/Office		
Individual Visit	**$25**	**Yes**
Group Visit, per day	**$5**	**Yes**

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES - Outpatient

Cost Sharing 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	Applies to OOP
Physical Therapy	**$25**	**Yes**
Visit Maximum	**Unlimited**	**N/A**
Occupational Therapy	**$25**	**Yes**
Visit Maximum	**Unlimited**	**N/A**
Speech Therapy	**$25**	**Yes**
Visit Maximum	**Unlimited**	**N/A**

MULTIDISCIPLINARY REHABILITATION

Benefit Type	You Pay and/or Maximums	Applies to OOP
Outpatient Services, per day	**$25**	**Yes**

SKILLED CARE		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Home Health Care Nurse visits (2 hours), Aide visits (4 hours), therapy visits, supplies associated with a visit.	**$0**	**Yes**
Visit Maximum	**3 visits per day 100 visits per calendar year**	**N/A**
Hospice Life expectancy of 12 months or less	**$0**	**Yes**
Respite Care for Home Hospice	**$0**	**Yes**
Respite Care Maximum	**Up to 5 consecutive days for each approved admission**	**N/A**
Skilled Nursing Facility		
Per Admission	**$0**	**Yes**
Day Maximum	**100 days per benefit period**	**N/A**

OTHER SERVICES		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Acupuncture Medically Referred for nausea, pain management	**$25**	**Yes**
Chiropractic Care Self-Referred	**$15**	**No**
Visit Maximum	**24 visits per calendar year**	**N/A**
Appliance Allowance	**$50 per calendar year**	**N/A**
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury.	**NOT COVERED**	**N/A**
Applied Behavior Analysis (ABA) A diagnosis of Autism Spectrum Disorder (ASD) is required for benefits to apply Note: Physical, Speech and Occupational therapies associated with the treatment for Autism are covered under the base therapy benefits.	**$25**	**Yes**
Durable Medical Equipment Includes Diabetic testing supplies and equipment and state mandated items.		
Base coverage	**20%**	**Yes**
Supplemental coverage	**20%**	**No**
External Sexual Dysfunction Device	**50%**	**No**
Prosthetics and Orthotics Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies and state mandated items.		
Base coverage	**$0**	**Yes**
Supplemental coverage	**$0**	**No**
Internally Implanted Devices	**$0**	**Yes**
Medical Foods Amino acid modified products and elemental dietary enteral formula	**$0**	**Yes**

OTHER SERVICES continued		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Vision Hardware - Contact Lenses Benefit Allowance may be applied to Contact Lens fitting fee		
Benefit Allowance (must be used all at once)	**$175**	**No**
Allowance frequency	**Every 24 months**	**N/A**
Allowance shared with Frames and Lenses	**Allowance shared with Frames and Eyeglass Lenses**	**N/A**
Vision Hardware - Frames and Eyeglass Lenses		
Benefit Allowance (must be used all at once)	**$175**	**No**
Allowance frequency	**Every 24 months**	**N/A**
Allowance shared with Contact Lenses	**Allowance shared with Contact Lenses**	**N/A**
Vision Hardware - Medically Necessary Contact Lenses		
Covered for the treatment of aniridia and aphakia	**$0**	**No**
Contact lens limits for treatment of Aniridia	**2 sets of lenses every 12 months**	**N/A**
Contact lens limits for treatment of Aphakia	**6 contact lenses per eye every 12 months**	**N/A**

TRAVEL AND LODGING For reasonable transportation and lodging that is primarily for and essential to receipt of a specific Covered Service where (1) the covered individual is unable to locate an In-Network provider in the State where the covered individual resides and (2) the covered individual must travel more than 50 miles to receive the Covered Service.		
Benefit Type	**You Pay and/or Maximums**	**Applies to Plan OOP**
Kaiser Permanente coordinated Travel and Lodging for Bariatric Surgery Includes coverage for recipient and companion/parent for transportation and lodging. Must travel more than 50 miles away from your home for surgery. Daily expenses for transportation and lodging are NOT COVERED.		
Transportation Limits Coverage includes one pre-surgical visit, actual surgery and initial post-surgical follow-up visit for patient (maximum 3 trips); actual surgery and initial post-surgical follow-up visit for companion (maximum 2 trips).	**Maximum of $130 for each round-trip.**	**N/A**
Lodging Limits Coverage includes one hotel room, double occupancy for patient/companion, up to 2 days per trip for one pre-surgical visit and post-surgical follow-up visit; one hotel room, double occupancy, for companion, up to 4 days, for patient surgery.	**Up to $100 per day**	**N/A**
Kaiser Permanente coordinated Travel and Lodging for Organ Transplants Includes coverage for recipient, caregiver and donor for transportation, lodging and daily expenses.		
Transportation Limits	**Unlimited**	**N/A**
Lodging Limits	**Unlimited**	**N/A**
Daily expenses include incidental expenses such as meals and does not include personal expenses.	**Reimbursement of actual expenses up to $100 per day**	**N/A**
Benefit Maximum	**Unlimited**	**N/A**
Benefit Lifetime Maximum	**Unlimited**	**N/A**

OUTPATIENT PRESCRIPTION DRUGS

Obtained from Network Pharmacies and on the Kaiser Permanente formulary (list of approved drugs), unless otherwise specified.

Note: Member will pay their copay or the full cost of the medication, whichever is less.

Benefit Type	You Pay and/or Maximums	Applies to Plan OOP
Generic	**$10 up to 30 days' supply $20 31-60 days' supply $30 61-100 days' supply**	**Yes**
Brand	**$30 up to 30 days' supply $60 31-60 days' supply $90 61-100 days' supply**	**Yes**
Note: Certain medications may be limited to 30-day supply**.**		
Mail Order Drugs		
Generic	**$10 up to 30 days' supply $20 up to 31-100 days' supply**	**Yes**
Brand	**$30 up to 30 days' supply $60 up to 31-100 days' supply**	**Yes**
Note: Certain medications may be limited to 30-day supply.		
Blood Factors	**$0**	**Yes**
Diabetic Coverage Some diabetic supplies may be covered under Durable Medical Equipment.		
Oral Medications and Insulin	**Generic/Brand**	**Yes**
Diabetic testing supplies (meters, test strips)	**20%**	**Yes**
Diabetic administration devices (syringes)	**Generic**	**Yes**
Fertility Drug Coverage	**NOT COVERED**	**N/A**
End of Life Drugs	**NOT COVERED**	**N/A**
Growth Hormone	**Generic/Brand**	**Yes**
Knox Keene Mandated Items Where applicable to Durable Medical Equipment, Prosthetics, and Orthotics.	**$0**	**Yes**
Oral Anti-Cancer Drugs	**Generic/Brand**	**Yes**
Sexual Dysfunction Quantity Limits Apply (based on medication prescribed)	**Generic/Brand**	**Yes**
Weight Loss	**NOT COVERED**	**N/A**
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis and stroke	**Generic/Brand**	**Yes**
ACA Mandated Drugs* (see Preventive Services for more information)		
Contraceptive Devices methods, and drugs (FDA-approved and prescribed by your doctor), contraceptive device removal, and female sterilizations.	**NOT COVERED**	**N/A**
Pre-Exposure Prophylaxis (PrEP) for HIV Prevention	**$0**	**No**
Emergency Contraception	**NOT COVERED**	**N/A**
Preventive Breast Cancer Drugs	**$0**	**No**
Smoking Cessation	**$0**	**No**
Statins (Cholesterol Lowering Agents)	**$0**	**No**

OUTPATIENT PRESCRIPTION DRUGS continued		
Benefit Type	**You Pay and/or Maximums**	**Applies to Plan OOP**
Preventive Over the Counter Products Preventive Over the Counter products are covered at a network pharmacy when prescribed by your provider for certain conditions.		
Aspirin	**$0**	**No**
Oral Fluoride	**$0**	**No**
Folic Acid	**$0**	**No**
Iron Supplements	**$0**	**No**
Female Contraceptives (spermicides, male and female condoms, sponges and emergency contraceptives)	**NOT COVERED**	**N/A**
Bowel Prep	**$0**	**No**
* With prescription, no cost share. Without prescription, Participant pays retail cost		
Refer to the Outpatient Prescription Drug section later in this document for coupon information.		
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Administered meds, etc.) Office Visit Cost Sharing for administration may apply.		

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 of your Benefits booklet.

- **Abortions** - Elective, Medically Necessary and Rape/Incest procedures.
- **Before coverage begins** - Any Services, drugs, or supplies you receive while you are not enrolled in this Plan
- **Behavioral / Conduct Problems** - Therapies and Services delivered in a non-clinical setting such as educational therapies and programs for behavioral/conduct problems.
- **Blood** - The cost of whole red blood or red blood cells when they are donated or replaced and billed, except expenses for administration and processing of Blood and Blood Products (except Blood Factors) covered as part of inpatient and outpatient Services.
- **Care by non-Network Providers-** Except for Authorized referrals, emergencies and out of area Urgent Care
- **Care in a Halfway House**
- **Contraceptive Drugs and Devices** - Including Emergency Contraception.
- **Cosmetic Services** - Except for medically necessary reconstructive surgery and related Services.
- **Custodial Care** - Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to Services covered under "Hospice Care"
- **Dental Services** - Not listed elsewhere in your coverage. This exclusion also applies to accidental injury to sound and natural teeth.
- **Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint** (also known as TMD or TMJ disorders)
- **Education** - Services other than Health Education or Self-Management of a medical condition as determined by the Plan to be primarily educational in nature.
- **Excluded Providers** - Services, supplies, equipment, or prescriptions provided by OIG (Office of the Inspector General) excluded providers.
- **Experimental or Investigational Services** - Kaiser Permanente, determines that a Service is experimental and investigational when:
    - Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients);
    - It requires government approval that has not been obtained when Service is to be provided;
    - It cannot be legally performed or marketed in the United States without FDA approval;
    - It is the subject of a current new drug or device application on file with the FDA;
    - It has not been approved or granted by the U.S. Food and Drug Administration (FDA) excluding off-label use of FDA approved drugs and devices
    - It is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives;
    - It is subject to approval or review of an Institutional Review Board or other body that approves or reviews research;
    - It is provided pursuant to informed consent documents that describe the Services as experimental or investigational, or indicate that the Services are being evaluated for their safety, toxicity, or efficacy; or

- The prevailing opinion among experts is that use of the Services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the Service;
- It is provided for Non-referred Services in connection to an approved clinical trial and/or Services in connection with a non-approved clinical trial;

Services related to Clinical Trials are considered Experimental and Investigational when;

- Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Items or Services needed for reasonable and necessary care arising from the provision of an investigational item or Service--in particular, for the diagnosis or treatment of complications.

- **Fertility Services -** The following and related Services:
  - 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 donor Services related to their procurement and storage, including cryopreservation
  - Any experimental, investigational, or unproven fertility procedures or therapies.

  This exclusion does not apply to Services to rule out the underlying medical causes of infertility.

- **Foot care-** Except when Medically Necessary
- **Gender Affirming Surgery**
- **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.
- **Hair Loss or Growth Treatment** - Items and Services for the promotion, prevention, or other treatment of hair loss or hair growth.
- **Hearing Aid Services** - Hearing Aids, hearing devices and related or routine examinations and Services.
- **Hypnotherapy** (Hypnosis)
- **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** - Massage therapy except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitation and Habilitation Services" in the "Benefits and Cost Sharing" section.
- **Medical Supplies** - Disposable supplies for home use, excluding urological and ostomy supplies.

- **Medicare Benefits** - Your benefits are reduced by any benefits to which You are entitled under Medicare except for Members whose Medicare benefits are secondary by law.
- **Network or Non-Network Provider (Close Relative)** – Services rendered by a Network or Non-Network Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother, or sister, by blood, marriage or adoption.
- **Nutritional supplements and formulas** - Except for formula needed for the treatment of inborn errors of metabolism
- **Obesity** - Fees or costs associated with weight reduction programs, fees and charges relating to fitness programs, weight loss or weight control programs, except for Network Diabetes prevention programs.
- **Outpatient Prescription Drugs**
    - Drugs prescribed for cosmetic purposes
    - Drugs that shorten the duration of the common cold
    - Drugs used to enhance athletic performance
    - As determined by Kaiser, Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product except where noted in your Schedule of Benefits
    - Experimental or Investigational Drugs
    - If a Service is not covered under this Plan, any drugs or supplies needed in connection with that Service are not covered
    - As determined by Kaiser, Prescription drugs for which there is an over-the-counter drug equivalent except where noted in your Schedule of Benefits
    - Replacement of lost, damaged or stolen drugs
    - Special packaging; packaging of prescription medications is limited to Kaiser Permanente standard packaging
    - Drugs used in the treatment of Fertility
    - Drugs used in the treatment of Weight Control
    - 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.
- **Private Duty Nursing** - In home or long-term facility.
- **Private room** - Unless Medically Necessary or if a semi-private room is not available
- **Recreational, diversional and play activities**
- **Religious, Personal Growth Counseling or Marriage Counseling** - Including Services and treatment related to religious, personal growth counseling or marriage counseling, unless the primary patient has a mental health diagnosis.
- **Services, drugs, or supplies if not Medically Necessary**
- **Services billed more than 365 days after the date of Service or dispensing.**
- **Services for conditions that a Network Physician determines are not responsive to therapeutic treatment.**

- **Services Provided Outside the United States -** Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States.
- **Services Related to a Non-Covered Service** - All Services, drugs, or supplies related to the non-Covered Service are excluded from coverage, except Services we would otherwise cover for the treatment of complications and rehabilitation of the non-Covered Service
- **Services that are the Subject of a non-Network Provider's Notice and Consent -** Amounts owed to non-Network Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable federal law.
- **Shoes -** Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace)**.**
- **Sterilization and Reversal of Sterilization**
- **Surrogacy** - Services related to conception, pregnancy, or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
- **Testing for ability, aptitude, intelligence, or interest**
- **Third Generation Dependents** - Services related to third generation dependents, unless enrolled as a dependent, (includes temporary enrollment under the plan for a limited number of days after birth).
- **Third Party Requests:** Services, reports and/or examinations in connection with employment, participation in employee programs, insurance, disability, licensing, immigration applications, or on court order or for parole or probation.
- **Travel or transportation expenses** - Expenses even though prescribed by a Network Physician or non-Network Physician except as noted as covered in the Summary of Benefits.
- **Vision-** Low vision aids, eyeglasses, and contact lenses for prescription or fitting and follow-up care thereof. Exception: The purchase of eyeglasses, lenses, frames or contact lenses following cataract surgery (first pair only) or loss of lens due to eye disease for aphakia or aniridia.
- **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 (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
- **Waived fees** - Free Services (no charge items)
- **Wigs and Toupees**
- **Workers' Compensation -** Services for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease, or similar law. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if covered by the Plan. Services or supplies for injuries or diseases related to you or your Dependent's job to the extent you or your Dependent is required to be covered by a workers' compensation law.

Please note:

A Service is Medically Necessary if, in the judgment 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.

To be a Covered Service, Services must meet the requirements as described in the Benefit Booklet.